- ***INTRODUCTION***

The purpose of the Atlanta EMA Ryan White Part A program is to improve the availability and quality of care for low-income, uninsured, and underinsured individuals and families affected by HIV disease in the 20-County Atlanta Eligible Metropolitan Area (EMA). Funds support a continuum of care, including both core medical and support services. Funds are also used to support the quality management program and Metropolitan Atlanta HIV Health Services Planning Council, the planning body that establishes service priorities and allocates funds in the EMA.

- ***NEEDS ASSESSMENT***

1. Demonstrated Need

1) A. HIV/AIDS Epidemiology

(1) **See Attachment 3.**

From 1981 to the end of 2011 the cumulative number of reported cases of AIDS in the United States (50 States and DC) was 1,138,211 [statistics for 2012 are not yet available from Centers for Disease Control and Prevention (CDC)] of which 518,163 (46%) were reported as living through 2010.[1] The South is increasingly the epicenter of this disease with 447,686 cases (39% of cases nationally) that is 31% greater than the Northeast, 94% greater than the West and 3.7 times greater than the Midwest. This trend has not changed in the last 5 years.[1]

In Georgia there have been 64,886 cases of HIV infection reported through December 2012 of which 42,640 were AIDS.[2] Georgia had the 6th highest number of AIDS cases among states in the US through 2011.[1] A subtotal of 42,654 (66%) was reported as living through 2012.[2]

The Atlanta EMA has had 46,962 cases of HIV infection reported through 2012 (72% of all Georgia cases), of which 32,480 were AIDS.[2] This number represents a 17% increase since 2010 and a 13% increase since 2011. National data rank the Atlanta Metropolitan Statistical Area (MSA) as the 3rd highest in AIDS diagnoses during 2011 between all MSA's and the 6th highest in cumulative cases.[1] Atlanta-Sandy Springs-Marietta, the Atlanta MSA, is the central area of the Atlanta EMA. Only 3 years ago the Atlanta MSA was the 14th highest highlighting the marked increase in infections.[2] **There were 31,469 Persons Living with HIV/AIDS (PLWHA) through 2012.**

Ryan White Part A sites provided services to 13,007 HIV infected clients in 2012. This has increased from 12,288 in 2010.

Testing for HIV was performed on 62,227 samples in the EMA during 2012 of which 870 were seropositive for HIV. These included both newly identified and existing infections. HIV Counseling and Testing data for calendar year 2012 in the EMA identified **545 new cases** of infection (a rate of 1.4%).[3] This rate has not declined in three years.

(2) **Description of the current HIV/AIDS prevalence in the EMA:**

(a) **HIV/AIDS Cases by Demographic Characteristics and Exposure Category**

The number of people living with HIV (PLWH): Through the end of 2012, there were 13,801 PLWH in the EMA.[2]

The number of people living with AIDS (PLWA): Through the end of 2012, there were 17,668 PLWA in the EMA.[2]

[1] CDC and Prevention, HIV Surveillance Report 2011; Vol. 23. Published 2013.
[2] HIV/AIDS Epidemiology Section, Georgia Department of Public Health, September 2013.
[3] HIV Prevention Unit, Division of Health Protection, Georgia Department of Public Health, August 2013.

The number of new AIDS cases reported within the past 3 years: There were 877 newly reported AIDS cases in 2010, 884 in 2011 and 1,745 in 2012.[2]

There has been a marked increase in reported cases in the last three years. The number of PLWH in 2012 has increased 23% since 2010 and the number of PLWA has increased 10%. The most notable increase is in the number of new AIDS cases reported in 2012 compared to 2010 and 2011 where there has been a **99%** increase. This increase is largely as a result of increased electronic reporting of lab results in the State and EMA, an aggressive campaign to collect and enter all lab data not previously entered, a thorough review of the National Death Index and an increase in newly reported cases.

Racial/Ethnic Patterns in HIV/AIDS Epidemiology:

The number of people living with HIV: Through the end of 2012, there were 8,386 African American PLWH in the EMA, 2,320 Whites, 672 Hispanics and 2,038 in whom racial/ethnic data were not provided.[2]

The number of people living with AIDS: Through the end of 2012, there were 11,741 African American PLWA in the EMA, 3,608 Whites, 979 Hispanics and 692 in which racial/ethnic origin was not provided.[2]

The number of new AIDS cases reported within the past 3 years: There have been 649 African Americans newly reported as AIDS cases in 2010, compared to 657 in 2011 and 908 in 2012. In Whites there were 129 in 2010, 109 in 2011 and 164 in 2012.[2]

African American PLWH represented 61% of the total HIV population and 73% of the population in which racial/ethnic origin was provided. This latter figure is 2% higher than 2010. Whites living with HIV have declined from 24% in 2010 to 17% in 2012. Hispanics have remained constant at 5%. African American PLWA represented 69% of cases in which racial/ethnic origin was provided, a 1% increase since 2010. Whites have declined from 25% in 2010 to 21% in 2012 while Hispanics increased from 5% to 6%.[2]

The increase in the number of newly reported cases of AIDS in African Americans is a 38% increase in 2012 over 2011. Over the same time period, new AIDS cases among Whites have increased 50%. New AIDS cases in Hispanics also increased to 67 in 2012, an increase of 22% over 2011.

Data extracted from the CAREWare database (data on clients attending Ryan White Part A funded sites in the EMA and maintained on a centralized database) found among the 13,007 clients treated in these clinics in 2012, 76% of clients were African American, a proportion that has risen from 75% in 2010; Whites represented 16% and Hispanics 5%.[4] Further discussion of African American MSM PLWH can be found in Section 1) D. (1).

HIV Counseling and Testing sites in the EMA during 2012 recorded 737 positive individuals (includes previously identified and newly identified HIV infection, seropositive rate of 1.6%) among African Americans that has remained steady over the last 3 years. Whites recorded 101 positive individuals (seropositivity rate of 0.7%) while the rate among Hispanics has increased from 0.6% to 0.9%.[3]

In summary, HIV is largely affecting African Americans.

Gender Patterns in HIV/AIDS Epidemiology:

The number of people living with HIV: Through the end of 2012, there were 10,585 male and 3,081 female (27 transgender) PLWH (135 without a recorded gender).[2]

The number of people living with AIDS: Through the end of 2012, there were 14,030 male and 3,573 female (39 transgender) PLWA (65 without a recorded gender).[2]

The number of new AIDS cases reported within the past 3 years: There were 713 newly reported AIDS cases in males in 2010, 649 in 2011 and 2,791 in 2012. There were 184 cases in females in 2010, 144 in 2011 and 873 in 2012.[2]

The number of male PLWH in 2012 represented an increase of 25% since 2010 while the number of female PLWH increased 9%. Male PLWA showed an increase of 12% from 2010, while female PLWA had a 16% increase. The number of males newly reported with AIDS in 2012 was a 291% increase compared to 2010, while female cases of AIDS showed an increase of 374%.

Overall among PLWHA in the EMA, 78% were male and 21% female. There was little difference in the proportions of male PLWA versus PLWH (79% vs. 77%).[2] Among clients at Ryan White Part A sites, 74% were male, 25% female and 1% transgender.[4] Further discussion of young female PLWH can be found in Section 1) D. (2) and transgender PLWH can be found in Section 1) D. (4).

HIV Counseling and Testing data in the EMA during 2012 identified 748 infected males (previously and newly identified, 2.6%) and 119 infected females (0.4%). The rate for males has risen slightly in the last year from 2.5% while the rate for women has remained constant. Among the transgender population, 3 tested positive out of 91 tested.[3]

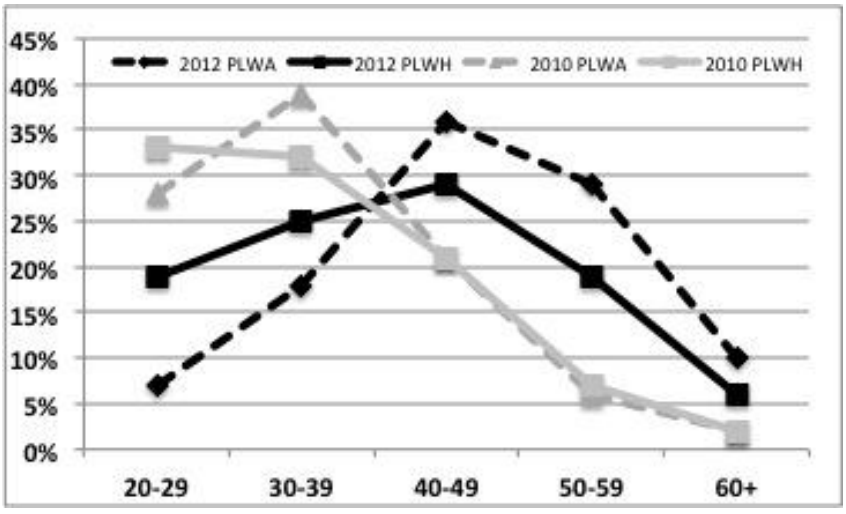
In summary, HIV is largely affecting males.

Age Group Patterns in HIV/AIDS Epidemiology:

The number of people living with HIV: Through the end of 2012, there were 2,771 PLWH in the EMA who were aged 13 to 29 years (20% of PLWH), 7,485 aged 30 to 49 years (54%) and 3,459 aged 50 or more (25%).[2]

The number of people living with AIDS: Through the end of 2012, there were 1,254 PLWA in the EMA aged 13 to 29 years (7%), 9,432 aged 30 and 49 years (53%) and 6,969 aged 50 and over (39%).[2]

The number of new AIDS cases reported within the past 3 years: There have been 305 newly reported AIDS cases in 2012 aged 13 to 29 years (17%), 1,034 aged 30 to 49 years (59%) and 404 aged 50 or over (23%). By comparison, in the group 13-29 there were 199 in 2010 and 217 in 2011; in the group 30-49 years there were 522 in 2010 and 483 in 2011; in the group 50 and over there were 156 in 2010 and 182 in 2011.[2]



HIV infection has been a disease of younger people over recent years. That trend is changing and was very noticeable among PLWHA in 2012. Among PLWA 7% were aged in their 20's (28% in 2010), 18% were aged in their 30's (39% in 2010), 36% were aged in their 40's (21% in 2010), 29% were aged in their 50's (6% in 2010) and

[4] Southeast AIDS Training and Education Center (SEATEC), Department of Family and Preventive Medicine, Emory University, Atlanta, Georgia, September 2013.

10% in their 60's (same in 2010) (Attachment 3). A similar breakdown was seen among PLWH.

In the figure, the solid lines represent PLWH and the dotted PLWA. The grey lines are for those in 2010 and the black lines in 2012. It is very apparent that the entire HIV population is aging as seen in the shift to the right of 2012 cases.

Not surprisingly, PLWA in the EMA through 2012 were older than PLWH. Sixty-one percent (61%) of PLWA were aged less than 50 years compared to 75% of PLWH. Thirty-nine percent (39%) of PLWA were aged over 50 years compared to 25% of PLWH. Whites tended to be slightly older than African Americans but there was little difference between males and

	20-29 yrs	30-39 yrs	40-49 yrs	50-59 yrs	60+ yrs
Positive rate	1.5%	1.4%	1.8%	1.5%	0.9%

females. Further discussion of aging PLWH can be found in Section 1) D. (3).

HIV Counseling and Testing data in the EMA during 2012 revealed the highest rate of seropositivity (both previously diagnosed and newly identified) among those aged 40-49 years (1.8%) followed by those aged 20-29 (1.5%), 50-59 (1.5%) and 30-39 (1.4%).[3]

In summary, HIV is increasingly affecting the older population.

Exposure Category Patterns in HIV/AIDS Epidemiology:

The number of people living with HIV: Through the end of 2012, there were 5,133 Men who have Sex with Men (MSM), 631 Heterosexual (HET), 368 Intravenous Drug Users (IDU), 278 MSM/IDU and 146 with other transmission risk PLWH in the EMA. 7,245 had no transmission category reported.[2]

The number of people living with AIDS: Through the end of 2012, there were 7,907 MSM, 1,451 HET, 1,285 IDU, 782 MSM/IDU and 149 with other transmission PLWA in the EMA. An additional 6,094 had no transmission category reported.[2]

The number of new AIDS cases reported within the past 3 years: In 2010 there were 375 MSM newly reported AIDS cases compared to 406 in 2011 and 360 in 2012. There were 46 HET cases in 2010, 30 in 2011 and 28 in 2012. IDU accounted for 18 in 2010, 32 in 2011 and 16 in 2012. MSM/IDU accounted for 20 in 2010, 6 in 2011 and 11 in 2012. Those of other or unreported transmission amounted to 418 in 2010, 410 in 2011 and 1,330 in 2012.[2]

Six transmission categories were selected for analysis: men who have sex with men (MSM), injecting drug users (IDU), men who have sex with men and also use IV drugs (MSM/IDU), high risk heterosexuals without known IV drug use (HET) and those with no identified or recorded risk (NIR/NRR). Since the number of cases among the other transmission categories was so small and inferences from these data would be unreliable, further examination of those cases has not been presented here.

Since 1981 among cumulatively reported cases in the EMA, 43% of reported cases of AIDS have been among MSM, 9% IDU, 4% MSM/IDU and 7% HET. A subtotal of 36% has been NIR/NRR.[2] Since reporting of HIV became mandatory throughout Georgia in 2004, 36% of reported HIV infections have been among MSM, 3% IDU, 2% MSM/IDU and 5% HET. A subtotal of 54% was NIR/NRR.[2]

Among newly reported cases of AIDS in 2012 (including those with no identified or recorded exposure risks), MSM account for 19%, IDU, MSM/IDU and HET combined account for only about 1%. The remaining 79% were NIR/NRR. It is difficult to determine the proportion of all reported cases even by extension. Among those reported cases of AIDS in the EMA in

2012 in which risk factors were reported, MSM accounted for 86% compared to 82% in 2010. High risk heterosexual contact cases resulted in 7% of cases in 2012 and 10% in 2010. Intravenous drug use accounted for 4% of cases in 2012 and 9% in 2010.[2]

Data for PLWHA indicate that MSM account for 41%, heterosexuals 6% and IDU 5%.[2] There is still a large proportion in which risk is yet to be confirmed (44%) although this proportion is markedly less than in newly reported cases (79%). Among those in whom exposure risks were reported, 73% were MSM, 11% HET and 9% IDU.[2]

MSM accounted for 53% of clients receiving care at Ryan White Part A clinics in the EMA, IDU 3%, MSM/IDU 2% and HET 36%. Less than 1% had no risk identified or reported.[4]

If we consider males having sex with other males as a route of infection with HIV, those who identify as MSM and those identifying as MSM/IDU would account for a total of 90% of all reported cases in 2012 and 78% of all PLWHA in the EMA through 2012. Using a similar logic, intravenous drug use would account for 7% of all reported cases in 2012 and 15% of all PLWHA.

Since data about high risk activities have not been included in the counseling and testing database since 2006, seroprevalence rates in these risk categories are not available in Georgia.

In summary, HIV is largely affecting MSM.

(b) Disproportionate Impact of HIV/AIDS

Within the EMA 77% of newly reported cases in 2012 in which racial/ethnic origin was reported was African American. This proportion has increased from 73% in 2010.[2] Whites made up 14% of reported cases in 2012 compared to 17% in 2010 and Hispanics 6% (6% in 2010). These proportions are almost identical among clients receiving services in the Ryan White Part A sites in the EMA during 2012.[4]

When race and gender are examined together, the disproportionate impact of HIV/AIDS on the EMA's African American community is further highlighted. African Americans account for 73% of all male and 85% of all female PLWHA in the EMA in which transmission category was reported. Whites made up 18% and 6% respectively.[2]

Whereas the proportion of cases still indicates that Hispanics account for a relatively small percentage of cases, the increase in the number of infected Hispanics exceeds those in other racial/ethnic groups. There has been an increase of 22% in the number of Hispanic PLWHA in the last 3 years from 1,351 in 2010 to 1,455 in 2011 to 1,651 in 2012.[2]

The ages of PLWHA differ when comparing Whites to African Americans. The median age of White male PLWH was 46 years compared to 39 years in African American males. The median age of White male PLWA was 50 years compared to 47 years in African American males. Among males aged less than 30 years, 7% of African American and 5% of White males were living with AIDS. Among those male PLWH, 25% of African American males and 21% of White males were aged less than 30 years. Further highlighting the disproportionate impact on the young African American males is the 49% of African American males aged between 20 and 40 PLWH compared to 42% of White males of the same age. Those aged 50 or more account for 50% of all White male PLWHA through 2012 compared to 43% among African American males. Among females, White PLWA aged 50 or more accounted for 44% compared to 42% in African Americans and White PLWH aged 50 or more were 29% compared to 27% among African American females.

In summary, African Americans are disproportionately affected by HIV.

There were 1,470 youth PLWHA in the EMA in 2012, an increase of 13% since 2011 (youth being defined as those aged between 13 and 25 years).[2] Of these, 440 had AIDS and

1,056 HIV non-AIDS; 80% were male, 75% were MSM, 79% were African American and 79% of African American youth were MSM (of those in whom transmission category was reported) further highlighting the disproportionate impact of this disease.[2]

In summary, Youth are disproportionately affected by HIV.

Rates of HIV infection among the homeless have varied little since early reports placed the infection rate between 3% and 20%.[5] It is estimated that within the US, 3.4% of the homeless population is infected with HIV or 3 times the rate found in the general population.[6] Using point-prevalence analyses from seroprevalence surveys, the Atlanta Eligible Metropolitan Statistical Area (EMSA)-HIV/AIDS Housing Plan estimated that about 10% of the homeless population was HIV infected, with African American males having the highest rate of infection (11%).[7] Similar data were found in San Francisco where 10.5% of homeless and marginally housed were found to be HIV infected;[8] in a University of Washington study that found HIV rates of 8.5% - 19.5% among the homeless;[9] the National Association of Social Workers found HIV rates up to 20% among homeless.[10]

Among clients of Ryan White Part A sites in 2012, 8% of 13,007 persons were homeless or in "unstable" housing conditions, 75% were male, 80% were African American, 53% were MSM and 37% HET.[4] The Housing Plan above also reported that the longer people remain homeless, the higher the infection rate (<6 months, 7% infection rate; >3 years, 13% infection rate).[7] In addition, seroprevalence rates were higher in the same at risk populations of homeless as found in non-homeless with rates highest among MSM (29.5%) and lowest in those without drug use or MSM as risk factors (5%).[8]

Seroprevalence rates in the Counseling and Testing sites were 2.6% for males, 0.4% for females, 1.6% among African Americans and 0.7% for Whites. The seroprevalence of 10% among the homeless, 11% among African American homeless and over 29% among MSM indicates these populations are disproportionately affected.

In summary, Homeless African Americans and MSM are disproportionately affected by HIV.

In 2012 there were 53,807 inmates of Georgia Department of Corrections facilities. There were between 907 and 997 infected with HIV (1,765/100,000 incarcerated population).[11] This number did not include those still unaware of their infection or those in smaller county jails. The majority is African American (93%), male (91%), aged between 25 and 64 (89%) and mostly infected sexually (87%). Due to their environment, further transmission categorization is difficult at best. The rate of prevalent infection of the incarcerated population was four times the rate of infection in the EMA population (425.8/100,000).[1, 12] A total of 230 of these are released annually of which 47% or 108 are released annually into the EMA.[12] The 2011/2012 Consumer

[5] Network to Study HIV and Homelessness. Health Care for the Homeless Clinician's Network, National Health Care for the Homeless Council, 2: 5; September 1998.
[6] HIV/AIDS and Homelessness. National Coalition for the Homeless, Washington, DC; 2009.
[7] Atlanta EMSA-HIV/AIDS Housing Plan, 2009March 1998.
[8] HIV seroprevalence among homeless and marginally housed adults in San Francisco. Robertson MJ, Clark RA, Charlebois ED, Tulsky Y, Long HL, Bangsberg DR, Moss AR. Am J Public Health. 2004 Jul;94(7):1207-17.
[9] Homelessness and HIV. J. Curry, AIDS Community Research Initiative of America, Summer 2000.
[10] HIV/AIDS and Homelessness. E. P. Tomasezewski, National Association of Social Workers HIV/AIDS Spectrum Project, 2011.
[11] Profile of inmate releases, CY2010, CY2011, CY2012, Annual Reports, Georgia Department of Corrections, 2013.
[12] Office of Pre-Release Coordinator, Georgia Department of Corrections, August 2013.

Survey (*The Consumer Survey*) data reported 11% of respondents had spent time in jail/prison, 75% received HIV care while housed, 33% received medicine supply on leaving, 21% received referral information and 40% received none of the services. Those not receiving services was due to issues of transportation (19%), documentation (16%), financial/insurance (13%), not knowing where to go (10%).[4]

In summary, Incarcerated persons are disproportionately affected by HIV.

(c) **Populations of PLWHA in the EMA that are underrepresented in the Ryan White Program-funded system of HIV/AIDS primary medical care**

Clients receiving any services from Ryan White Part A sites are predominantly African American and closely match the age ranges of PLWHA in the EMA. However, only 53% of clients are MSM in a population in which less than 1% did not report or record a transmission category. Among newly reported cases of HIV infection during 2012 and in which transmission category was recorded, 88% were MSM and 73% of PLWHA in the EMA were MSM. Hence, MSM are under-represented as clients in the Ryan White Part A sites.[4]

There were 1,460 youth reported as PLWH in the EMA in 2012. Data from the Ryan White Part A sites indicate there were 829 youth accessing any services at those sites. Thus 43% or 631 young PLWH are not accessing services and are underrepresented in the Ryan White Part A sites.

A total of 4,295 females aged between 13 and 49 were living with HIV in the EMA in 2012. The majority were PLWH (58%) and African American (76%). Females of this age and accessing Ryan White Part A services numbered 1,126 or 56% meaning that 45% were not being seen at these sites.

(d) **Estimated level of service gaps among PLWHA in the EMA**

Service gaps were documented in surveys carried out by the Metropolitan Atlanta HIV Health Services Planning Council in the EMA during the past 2 years. These included *The Consumer Survey*, Adolescent Focus Group (2010), Mental Health and Substance Abuse Focus Group (2010), Transgender Focus Group (2012) and a survey of Hispanic clients (2012).

The Consumer Survey collected data concerning services accessed by PLWHA at 15 Part A and 3 non-Part A service sites through interview of 715 clients. The five services most needed and not received (and the proportion who did not receive these services) were *food vouchers (40%), dental treatment (28%), nutritional supplements (28%), emergency dental care* (24%) and *preventive dental treatment (24%).* The gaps varied by race and ethnicity, see Table 1. Among Hispanics 38% did not receive food vouchers compared to 39% of African Americans and 42% of Whites; preventive dental care was not received by 20% of Hispanics compared to 24% of African Americans and 33% of Whites.[4]

Table 1: Percentage Not Receiving Top 5 Needed Services

	African American	Hispanic	White
Food vouchers	39%	38%	42%
Dental care	29%	35%	30%
Nutritional supplements	28%	38%	28%
Emergency dental care	25%	30%	27%
Preventive dental care	24%	20%	33%

The need for food vouchers was uniform across racial and ethnic groups as was oral health needs.

While there were small numbers of transgender identified clients surveyed [n=16], the population had the highest percent of gaps in services. Six categories have gaps in excess of 30%: "*dental treatment"* (63%), "*food*

pantry" (50%), "*emergency dental care"* (38%), "*nutritional supplements"* (38%), "*preventive dental care"* (31%) and "*food vouchers"* (31%).

1) B. Impact of Co-Morbidities on the Cost and Complexity of Providing Care

(1) The estimated number of people in the EMA's general and PLWHA populations who have sexually transmitted infections (STIs), have TB, are homeless, do not have health insurance, and live in poverty or near poverty levels are given in **Attachment 4**.

To determine the cost of caring for PLWHA in FY14, data were used from the Presentation of Special Studies made to the Priorities Committee of the Atlanta EMA Planning Council in May 2013. Total costs for each core component and each service component were aggregated and divided by the total number of PLWHA who accessed any of the services at Ryan White Part A sites to provide a cost per client per year. This resulted in a cost of $8,011/client/year.

Between 2010 and 2011, there was an increase of 2% in the number of PLWHA seen in Ryan White Part A sites. Between 2011 and 2012 there was a 4% increase. In order to project the estimated total number of PLWHA requiring services in FY14, the number in 2012 has been increased by a conservative 3% to 13,397. Similarly, the number without any insurance has been increased by 3% to 8,402. This is a conservative estimate during this time of transition into the new ACA environment. The number of PLWHA for 2014 has been increased by 3% to 32,413.

CATEGORY	2012/client	# clients	Estimated cost
Primary care	$1,267	8,402	$10,645,334
Oral health	$596	13,397	$7,984,612
Case management	$493	13,397	$6,604,721
Mental health	$508	8,402	$4,268,216
Substance abuse	$763	8,402	$6,410,726
Medications	$846	8,402	$7,198,092
CORE SERVICE SUBTOTAL	**$4,473**		**$43,111,701**
Food pantry/nutrition	$183	13,397	$2,451,651
Home delivered meals	$1,661	13,397	$22,252,417
Emergency assistance	$56	13,397	$750,232
Psychosocial support	$117	13,397	$1,567,449
Medical transportation	$78	13,397	$1,044,966
Legal	$943	13,397	$12,633,371
Linguistic	$270	13,397	$3,617,190
Childcare	$230	13,397	$3,081,310
SUPPORT SERVICES SUBTOTAL	**$3,538**		**$47,398,586**
Cost/client/year	$8,011		
Insurance premiums/copays/deductibles			$2,200,000
TOTAL	**$8,011**		**$92,710,287**

Plans through the Health Insurance Marketplace will not cover oral health, case management or any of the support services. For those clients on some form of insurance, the cost of providing those exempted services have been included in the cost calculation. So the cost of all clients, regardless of insurance status, for oral health, case management and support services

have been included. The cost of primary care, mental health, substance abuse and medications has only been included for the 8,402 clients without health insurance.

The total cost of providing uncompensated core services is estimated to be $43,111,701 and for support services $47,398,586. The total cost of providing care through the Ryan White Part A sites, including $2.2 million for insurance premiums, copays and deductibles under the Affordable Care Act (ACA) will be **$92,710,287**.

(a) **STI Rates:** HIV disease is an STI, and documenting the prevalence of other STIs, and hepatitis B and C also captures the potential risk of infection with HIV.[13,14,15,16]
The STIs which are the best indicators to examine are chlamydia, gonorrhea, and syphilis as all are reportable diseases in Georgia. Detailed analyses of these data are presented here for cases reported in 2011, the most recent data available. It is alarming to note that as with HIV infection described earlier, Georgia is one of the highest ranking states in the country for rates of STIs and is increasing those rates every year.

Chlamydia: There were 50,950 reported cases of chlamydia in 2011 in Georgia.[17, 18] In 2011, Georgia had the 7th highest chlamydia rate in the country at 562 cases/100,000.[18] This rate has climbed in the last year from 466/100,000 in 2010 and Georgia's rating has "declined" from 14th in 2010. Within the EMA there were 25,735 reported cases, an increase of 19% from the previous year of 2010 for a rate of 495/100,000.[17]

Of the reported cases, 18,382 (71%) were among women resulting in a case rate of 689 cases/100,000, more than double the rate for men of 278 cases/100,000.[17] Among PLWHA receiving primary care in the Ryan White Part A clinics in the EMA and who responded to *The Consumer Survey*, 9% reported a history of chlamydial infection. Using this percentage results in 2,917 cases of chlamydia among PLWHA in the EMA (9% of 32,413). Cases were 81% male, 84% African American and 72% were MSM.[4]

African Americans accounted for 84% of all cases in the EMA where race or ethnicity was reported.[17] The age group most affected was the young adult aged between 20 and 29 years of age among whom there were 13,430 cases, an increase since the previous year of 24% (1,894 cases/100,000, a 50% increase in rate over the previous year). This was followed by those aged between 13 and 19 with 8,689 cases (1,676 cases/100,000).[17] Among those in which racial data were reported African Americans accounted for 85% of 13-19 year olds (1,670 cases/100/000) and 82% of 20-29 year olds (2,141 cases/100,000).[17]

Among males, African Americans had a case rate of 478/100,000, 16 times the rate in all White males; 16 times the rate of White males among 13-19 year olds (926 vs. 59/100,000), 13 times the rate in 20-29 (1,745 vs. 129/100,000) and 30-44 year olds (355 vs. 28/100,000).

Data present a worse picture when looking at just females. The rate among African American females was 694/100,000 compared to the 478/100,000 for African American males. The rate for all 13-19 year old females increased 13% from 2010 to 2,709 cases/100,000 (3% or

[13] The Hidden Epidemic: Confronting Sexually Transmitted Diseases. Institute of Medicine, 1998.
[14] Incident HIV infection among men attending STD clinics in Pune, India: Pathways to disparity and interventions to enhance equity, Shepherd ME, Gangakhedkar RR, Sahay S, et al. Journal of Health, Population and Nutrition: Vol. 21, 3, 2003.
[15] Classical sexually-transmitted diseases drive the spread of HIV-1: back to the future, Cohen MS. Journal of Infectious Diseases: 206: 1: 1-2.
[16] Prediction of HIV Acquisition Among Men Who Have Sex With Men, Menza TW, Hughes JP, Celum CL and Golden MR. Sexually Transmitted Disease: 2009: 36(9): 547-555.
[17] OASIS, Office of Health Indicators for Planning, Georgia Department of Public Health, August 2013.
[18] Division of STD, National Center for HIV, STD and TB Prevention, CDC, 2012.

1 in every 37 females) in 2011. Among all females aged 20-29 years, the rate increased 27% from 2010 to 2,677 cases/100,000 (3% or 1 in every 37 females). These rates are 10 times higher than those for males in the same age groups. Among females aged 13-19 years the rate among African American females was seven times that of White females. Among 20-29 and 30-44 it was 6 times the rate of White females.[17]

In summary, chlamydial infection in the EMA is more common among African Americans and females.

Gonorrhea: A total of 15,668 cases of gonorrhea were reported in Georgia in 2011 of which 8,338 were in the EMA.[17, 18] Georgia ranked 6th nationally in the rate of gonorrhea cases in 2011.

In the EMA, there were 8,338 (53% of statewide cases, rate of 160/100,000)) cases reported of which 3,972 were female.[17] The female case rate in the EMA was 149 cases/100,000. Females accounted for 47% of all cases and African Americans 59% of all gonorrhea cases. Again, the age group most affected was aged between 20 and 29 years accounting for 52% of all cases (609 cases/100,000). This was followed by those aged 13-19 years with 27% of all cases (437 cases/100,000).[17]

Further breakdown revealed that among females aged 20-29 in whom race was reported, 90% were African American with a case rate of 720 cases/100,000.[17] This case rate was 13 times that of White females. Among 13-19 year old females African Americans accounted for 91% with a case rate of 706 cases/100,000 that was 15 times that of White females. The same is seen among women 30-44 years of age, where African American females had a case rate 9 times that of White women.[17] Recent studies have suggested rates of rectal gonorrhea in HIV negative MSM is markedly higher in African Americans than Whites and will likely result in increasing HIV infection rates.[19]

Among clients at Ryan White Part A clinics in the EMA, 11% reported a diagnosis of gonorrhea. That would convert to 3,565 cases among PLWHA (11% of 32,413). Those with gonorrhea were male (93%), African American (82%) and MSM (85%).[4]

In summary, Gonorrheal infection in the EMA is more common among Young African American MSMs.

Syphilis: In Georgia there were 2,473 cases of all types of syphilis reported in 2011.[17] This ranks the state as 6th in the US in terms of actual numbers of cases and 2nd in syphilis rates.[18] When only primary and secondary cases were analyzed, there were 708 cases of which 141 were primary syphilis. Only 49 of those were female and 549 were African American.[17] Georgia ranked third highest in the US case rate for primary and secondary syphilis in 2011 at7 cases/100,000 and third highest for males (13/100,000).[18]

In 2011, 1,911 (77% of all Georgia cases) were newly reported cases of all forms of syphilis from the EMA. This resulted in a case rate of 37 cases/100,000.[17] The case rate for all forms of syphilis is the 6th highest in the nation based on 2010 data. Among the 860 newly reported cases solely of primary and secondary syphilis in Georgia, 82% (708) were reported from the EMA, an increase of 13% compared to 2010.[17] The case rate of the Atlanta EMA was 13 cases/100,000 for 2011.

Among PLWHA being treated at Ryan White Part A sites there were 1,416 clients who were positive for syphilis, 11% of all clients in 2012. African Americans made up 79% of these

[19] Chlamydia, gonorrhea and syphilis incidence among black and white HIV-negative men who have sex with men (MSM) in Atlanta, GA. O'Hara, B, Kelley C, Rosenberg E, et al. International AIDS Conference Proceedings, August 2012.

cases, 90% were male and 79% MSM.[4] Among those who responded to *The Consumer Survey*, 24% reported a history of syphilis.[4]

Using data for the standard metropolitan statistical areas, the Atlanta SMSA ranks 4th highest in case rate of syphilis for 2011.[18] Two of the major counties in the EMA, Fulton and DeKalb Counties have the 3rd and 12th highest rates respectively of all counties in the nation and between them account for 75% of all cases of primary and secondary syphilis in the EMA. Unlike gonorrhea, women accounted for only 7% of cases of primary and secondary syphilis in the EMA while African Americans account for 78% of newly reported primary and secondary syphilis cases in 2011.[17]

In the EMA in 2011, African American females had case rates higher than White females (4.8/100,000 vs. <1/100/000) although there were only 49 reported cases in females. Among 13-29 year old males, the African American rate of 119.9/100.000 was 20 times that of White males (6.1/100,000), and 5 times among white males aged 30-44 years.[17] The numbers among females were too small for a similar comparison.

Utilization data from 2012 indicate that 11% of all PLWHA who received any service at Ryan White Part A sites also had an associated STI, although the numbers reporting an STI were incomplete.[4] Three percent (3%) of clients with one STI had one other STI and 2% had three STIs. The CDC Supplement to HIV AIDS Surveillance Study documented that 20% of PLWA had one or more active STIs and 78% had a history of one or more STIs. By any measure these levels are extremely high and a cause for great concern for the partners of these clients who may not be aware of the sexual status and history of their partner(s).

In summary, Syphilis infection in the EMA is more common among African Americans and MSMs.

Hepatitis: In 2012 a total of 882 (6.8%) clients at the Ryan White Part A clinics had evidence of hepatitis B infection and an additional 117 (0.9%) had hepatitis C. Using these percentages there were 2,204 PLWHA in the EMA with hepatitis B and 292 with hepatitis C. Males accounted for 83% of hepatitis B and 70% of hepatitis C. African Americans represented 78% of hepatitis B and 74% of hepatitis C. MSM made up 93% of hepatitis B but only 40% of hepatitis C. By comparison, 26% were HET in hepatitis B and 36% of hepatitis C while 3% were IDU in hepatitis B and 15% in hepatitis C.[4] Hepatitis in this population is among African American MSM.

In summary, hepatitis B infection in the EMA is more common among African American MSMs while hepatitis C is more common among African American HET and IDU.

Tuberculosis: Although not an STI, TB has re-emerged largely as a result of HIV infection and is becoming increasingly resistant to standard medications. Co-infection with TB and HIV results in a huge cost increase, increased difficulty in treating HIV infection and a prolonged recovery time.[20] In Georgia there have been 411 cases of TB reported in 2011 (347 in 2010) of which 252 were in the EMA (214 in 2010). Georgia has the 9th highest rate of TB among states in the US.[21] Of those in the EMA, 62% were among males and 50% among African Americans. However, 51% of the males were African American and 19% White. Twenty-two percent (22%) of all reported cases of TB in males were Asian and 28% of all reported cases among females were Asian. The peak age grouping was 20-29 years of age for

[20] Georgia Department of Public Health, Division of Public Health, Infectious Disease Notification Report, August 2012.
[21] National Center for HIV/AIDS, CDC, 09/2010.

females and 40-49 years for males: 50-59 in Whites and African Americans and 20-29 in Asians. Co-infection with HIV was seen in 10% of those persons with TB, similar to the 11% in 2010.[22]

Among clients at Ryan White Part A sites in the EMA, 68 (0.5%) had been diagnosed with TB. 51 (76%) were male, 69% were African American, 51% HET and 42% MSM.[4] Using the percentage of clients with TB results in 162 PLWHA in the EMA also living with TB (0.5% of 32,413). There have been multiple outbreaks of TB identified in homeless people and shelters.[23,24,25] Major contributing factors to the susceptibility to TB among the homeless include poor hygiene, poor diet, drug and alcohol abuse and generally poor healthcare all of which result in a decreasingly effective immune system. This subpopulation can, therefore, become a reservoir of HIV and TB.

In summary, TB infection is more common among African Americans, HETs and MSMs.

(b) **Prevalence of Homelessness:**

Documenting the number of homeless persons at any given time remains a significant challenge. The national 2012 Point-in-Time Estimates of Homelessness Report ranked Georgia and the Atlanta metropolitan area 5th highest in the number of short and long term homeless people in the US at ***6,811***.[26] Atlanta had the 5th largest number of homeless veterans in the country, estimated to be about 1,232 veterans (2011 data).[26] A 2009 report from the Georgia Department of Community Affairs reported there were ***9,613*** people defined as Point-Of-Time homeless in the EMA.[27]Two other reports have suggested the numbers of homeless to be ***7,175***[28] and ***6,838***,[29] both in 2011, although both of these included only three counties and two cities (included in those counties) in their estimates.

Data from the Ryan White Part A sites indicate that 36% (1,092) of clients in 2012 were homeless or living in unstable living conditions which if extrapolated to the EMA would be ***11,669*** (36% of 32,413 PLWHA).[4] *The Consumer Survey* found 25% of respondents were homeless or in unstable housing in the previous year.[4] Data from *The Consumer Survey* would suggest a lower number of ***7,867***.

These estimates are remarkably close so an average is being used to provide an estimate of the prevalence of homelessness in the EMA which is 9,768 homeless persons, 25% of whom are PLWHA.

In summary, the prevalence of homelessness is an estimated 9,768 of which an estimated 2,442 are PLWHA.

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[22] CDC, MMWR, 53:2004.

[23] Tuberculosis Transmission in a Homeless Shelter Population – New York, 2000-2003. MMWR:2005: 54(06); 149-152.

[24] Public Health Dispatch: Tuberculosis Outbreak Among Homeless Persons – King County, Washington, 2002-2003. MMWR:2003:52(49);1209-1210.

[25] Tuberculosis Outbreak Associated with a Homeless Shelter – Kane County, Illinois, 2007-2011. MMWR:2012:61(11);186-189.

[26] The 2012 Point-in-Time Estimate of Homelessness, Volume 1 of the 2012 Annual Homeless Assessment Report, The US Department of Housing and Urban Development, Office of Community Planning and Development, Dec 2012.

[27] 2009 Report on Homelessness, Georgia Department of Community Affairs, Atlanta, GA 09/2009.

[28] Point-in-Time Estimates of Homelessness: Supplement to the Annual Homeless Assessment Report, US Department of Housing and Urban Development, December 2011.

[29] Point-of-Time Homeless Estimate, Atlanta City, Fulton and DeKalb Counties, Tri-Jurisdictional Homeless Census Report, 8.2.11 v 4.doc, 2011.

(c) **The number of persons without insurance coverage (including those without Medicaid and Medicare):**

Nationally 15% of the general population was uninsured in 2011.[30] In Georgia, 20% are uninsured, 14% have Medicaid, 10% have Medicare and 53% have private health insurance.[31] In the general population of the EMA, lack of health insurance coverage ranges from 10% to 23% with a median of 20%. In clients of Ryan White Part A sites in the EMA, 7,222 (56%) clients were uninsured, 2,057 (16%) had Medicare, 1,948 (15%) Medicaid and 1,451 (11%) had private insurance.[4]

In the absence of other definitive data we have applied the proportions above to the total projected population of PLWH in the EMA (See section 1) B. (1). This results in 18,152 (56% of 32,413) who have no health insurance, 5,186 with Medicare, 4,862 on Medicaid and 3,565 on private insurance.

(d) **The number and percent of persons living at or below 300% of the 2013 FPL:**

In 2013 the Federal Poverty Level (FPL) for a household of one is $11,490 and 300% of that will be $34,470.[32] The FPL for a household of two is $15,510 and 300% will be $46,530. In the EMA, 11,126 PLWHA lived in a household of one person, 1,049 lived in a household of two and the remaining 832 in larger households. The median household size was one. The median income was $11,287.[4]

In households of one among clients being seen at Ryan White Part A sites in the EMA, the income was below the FPL in 7,124 PLWHA and between the FPL and 300% FPL in another 2,801 resulting in 9,925 living at or below 300% FPL. In two person households respective numbers were 624 and 384 for a total of 1,008. Among the remainder there were 564 below FPL and 204 between FPL and 300% of FPL. The total number living at or below 300% of FPL was 11,701 or 90% of Ryan White Part A clients.[4]

Extrapolating these proportions, (90% living at or below 300% FPL), and applying them to the PLWH population in the EMA results in **29,171 living at or below 300% FPL**.

(e) **Identify trends in services and fiscal resources as a result of municipal and state budget cuts in HIV related and funded clinical and non-clinical services:**

Just a few years ago Georgia was a leading state for job growth. But Georgia ranks 32nd in job growth since the beginning of the recession in 2007. In fact, Georgia is down 387,000 jobs since the economic downturn hit. Overall, the state still is home to far fewer jobs than before the economic collapse and the recovery is slow. Georgians still face a long road to full economic recovery. The budget for the 2014 fiscal year includes several hundred million dollars in cuts on top of the billions in cuts made over the past five years. Many state agency budgets are 20 to 30 percent less than their levels during the 2009 fiscal year.

Georgia's public health programs in 2014 largely depend on funding from the federal government. Federal money accounts for 61% of the department's budget of more than $700 million. As recently as 2012, Georgia's state investment in public health ranked as fifteenth lowest in the U.S. and was nearly 40% below the national median. Georgia's spending on public health is only about 5 cents a day per person. Since 2009, state funding for public health has been cut by 5% annually.

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[30] CDC, National Center for Health Statistics, 2011.

[31] The Henry J. Kaiser Family Foundation State Health Facts, Urban Institute and Kaiser Commission on Medicaid and the Uninsured, Census Bureau Current Population Survey, September 2013.

[32] Federal Register, Vol 78, No 16, January 24, 2013, pp 5182-5183.

The Revenue Shortfall Reserve (RSR) is Georgia's "rainy day" fund, established to help Georgia get through tough economic times. The RSR acts as a savings account for the state should revenue collections decline unexpectedly. The RSR can fill the gap in funding and prevent additional budget cuts. At the end of FY07, the Revenue Shortfall Reserve (RSR) contained $1.5 billion. Governor Sonny Perdue used more than $1.4 billion in RSR funds to help balance the state budgets in fiscal years 2008, 2009, and 2010. By the end of the 2010 fiscal year, the fund contained only $116 million. The RSR at the end of FY11 contained only $355 million. A small surplus in the 2013 budget allowed the state to increase reserves to $378 million from $328 million.

High unemployment, years of budget cuts, and an outdated revenue system threaten the state's ability to educate its children, provide health care for the elderly, and ensure the safety of all communities. Among the states, it ranks:

- 5th in the number of residents without health insurance
- 50th (out of 51) in Medicaid expenditures per beneficiary (28% below national average)
- 11th for the number of children living in poverty (26.% , or 646,824 children)
- 5th for poverty among all ages (19.1%, or 1,827,743 Georgians)
- 49th in state revenue per person

Georgia has decided not to take advantage of billions of dollars in new federal funding to expand Medicaid coverage to hundreds of thousands of uninsured Georgians in 2014. Federal funding will cover 100% of the costs for newly eligible Georgians for three years; the state will be responsible for 10% of the costs for newly eligible Georgians beginning in FY20. Georgia's Governor, Nathan Deal, has stated that he will not expand the Medicaid program under the federal Affordable Care Act, which would have provided an estimated 600,000 low-income Georgians with health coverage, because it would be too expensive.

(2) **Explanation of Attachment 4:**

Chlamydia: There were 25,735 reported cases of chlamydial infection in the general population of the EMA in 2011.[17] Based on *The Consumer Survey* report, 9% of PLWHA had chlamydial infection. There are estimated to be 2,917 (9% of 32,413) cases among PLWHA in FY14.[4] The cost of treating a single case of chlamydia is about $584 in 2010 dollars.[33,34] The estimated total annual cost to treat chlamydia in PLWHA is $1,703,528. This does not include treatment of females infected with chlamydia with resultant chronic pelvic inflammatory disease and infertility.

Gonorrhea: There were 8,338 cases of gonorrhea in the general population of the EMA in 2011.[17] *The Consumer Survey* found 11% of clients reported gonorrheal infection. Thus there are estimated to be 3,565 cases of gonorrhea in PLWHA in FY14 (11% of 32,413). There are many estimates of the cost of treating a single case of gonorrhea but they all suggest it to be about $125.[34] The estimated cost of treating gonorrhea in PLWHA is $445,625 in FY14.

Syphilis: There were 1,911 reported cases of syphilis in the EMA in 2011.[17] Data from the Ryan White Part A sites found 1,416 cases of syphilis in 2012 (10.8% of the clients seen at those sites). There are estimated to be 3,500 cases of syphilis among PLWHA in the EMA in FY14 (10.8% of 32,413). The best estimate of the cost of treating syphilis, primary through neuro-syphilis, is $444.[344] The cost of treating syphilis in PLWHA is $1,554,000 in FY14.

[33] CDC, MMWR, April 1, 2011 / 60(12);370-373.

[34] Chesson H, Blandford J, Gift T, et al. The estimated direct medical cost of sexually transmitted diseases among American youth, 2000. Perspect Sexual Reprod Health 2004;36;11--9.

Hepatitis B: There were 882 cases of hepatitis B in the Ryan White Part A sites in 2012 (6.8% of all clients).[4] Extrapolating to all PLWHA would suggest there will be 2,204 PLWHA also with hepatitis B in FY14. The best estimate of the cost of treating a case of hepatitis B is $779.[34] The cost of treating hepatitis B in PLWHA would be $1,716,916 in FY14.

Hepatitis C: There were 117 cases of hepatitis C among clients at Ryan White Part A sites in 2012 (0.9% of all clients).[4] Extrapolating to all PLWHA results in 292 cases of hepatitis C in PLWHA in FY14. The best estimate of the cost of treating a case of hepatitis C is $37,620[35] although the range is large and dependent on strain. The cost of treating hepatitis C in PLWHA would be conservatively estimated at $10,985,040 for FY14.

TB: There were 252 cases of TB reported in the EMA in 2011. Sixty-eight of those were in clients of Ryan White Part A sites (0.5% of all clients). Extrapolation results in 162 cases of TB in PLWHA in the EMA in FY14. The estimated cost of treatment of a case of non-drug resistant TB is $30,000.[36] Thus the cost of treating simple drug sensitive TB in PLWHA would be $4,600,000 in FY14. However, it must be noted that perhaps 10% of cases are drug resistant. Treatment costs of those cases are 10 times the cost of simple TB and are not included here.

Homelessness: It was estimated, using multiple data sources, that there are 8,272 homeless individuals in the EMA. Data from the Ryan White Part A sites indicate 25% of clients were homeless. Applying this proportion results in 2,068 homeless PLWHA in FY14. The basic cost of treating HIV has been estimated as $8,011/client/year. Homeless individuals have higher rates of mental health disease and alcohol and substance abuse, all of which result in greater morbidity. The cost to treat their HIV disease is conservatively estimated to be $16,566,748 in FY14 without allowing for the increased cost of managing other illness.

No health insurance: Fifty-six percent (56%) of clients seen in Ryan White Part A sites were uninsured, 32% had Medicaid/Medicare/Champus/VA coverage and 12% had private or other coverage. Using these proportions and applying it to the estimated 32,413 PLWHA in 2014 there will be 18,151 PLWHA without insurance. The cost of treating these will be $145,407,661 at $8,011/client/year.

Poverty: Data from the Ryan White Part A sites found the total number of PLWHA living at or below 300% of FPL was 11,701 or 90% of clients. The number of PLWHA at or below 300% of FPL in the EMA for 2014 is 29,172 (90% of 32,413). Using the cost per client per year of $8,011 results in a cost of care for those in poverty of $233,696,892 in FY14.

(3) **Complexity of care and impact on the service delivery system of released prisoners**

The number of inmates released in 2010 was 21,783 of which 259 were infected with HIV, 2011 was 21,390 with 254 infected and 2012 was 19,316 with 230 infected. In each of those years 45% of the released inmates returned to one of the 20 counties in the EMA. In 2012 there were a minimum of 284 released inmates Ryan White Part A living in the EMA. The majority of infected released inmates is African American (93%), male (91%), aged between 20 and 39 (63%) and mostly infected sexually (87%). Due to their environment, further transmission categorization is difficult at best.[37]

In the released inmate population 69% are unmarried. Mental illness is being treated in 20%, substance abuse occurs in 31% and 56% are in need of moderate to extensive dental

[35] Helsper CW, Hellinga HL, van Essen GA, et al. Real-life costs of hepatitis C treatment. Neth J Med 2012 Apr;70(3):145-53.
[36] Dye C, Floyd K. Disease control priorities in developing countries, 2nd edition. The World Bank Group.
[37] Profile of inmate releases, CY2010, CY2011, CY2012, Annual Reports, Georgia Department of Corrections, 2013.

treatment. They test positive for TB in 15%, syphilis in 1% and hepatitis C in 1%. In 2012, 22% had some form of chronic illness requiring treatment (diabetes, hypertension or heart disease). All infected inmates are cared for by the medical staff, but this requires transportation to a single facility in Augusta, Georgia, about 2 hours east of Atlanta. Telemedicine is used in between these trips as needed.

Just prior to release from prison, HIV infected inmates may enter a pre-release program. At that point an appointment is made for a Ryan White Part A clinic and copies of their medical files are prepared and ready to be given to the inmate on release and also sent to the clinic. If they are on HAART they will receive a 14 day supply. However, in 2012 only 745 inmates infected with HIV were receiving HAART of the 908 infected and incarcerated (14% are not receiving HAART). There is only one staff person for this pre-release program who is only able to see about 40 infected inmates on release. The remaining 63% of infected inmates are discharged by the general medical staff and appointments with Part A clinics often are incomplete. These discharges often do not receive the usual 14 day supply of HAART medications or the 7-30 days of chronic illness medications, do not receive a copy of their medical record and appointments for providers are not made. Clients are often homeless and difficult to contact.

The Consumer Survey data found 11% of respondents had spent time in jail/prison, 75% received HIV care while in prison, 33% received medication supply on leaving, 21% received referral information and 40% received none of the services. Those not receiving services were due to issues of transportation (19%), documentation/identification (16%), financial/insurance (13%) and not knowing where to go (10%).[4]

It is difficult to estimate the cost of caring for released inmates. However, the assumption can be made that the cost to provide care for the 284 inmates will be the same as other PLWHA ($8,011). In addition, 22% have some form of chronic illness. As detailed in the table in the next section (**1) D. Assessment of Populations with Special Needs, (3) Aging PLWHA**), the cost per year to manage just four conditions is estimated to be $11,592. So 22% of released inmates (62 inmates) will incur that cost also. In addition, those with TB have a higher than usual multi-drug resistant strain of TB than the general population. Estimates range from 2-55% globally but are closer to 2% in the US, so there may be 1-2 in the inmates released to the EMA. Multi-drug resistance raises the cost of treatment to over $300,000 per patient per year. Total cost can be estimated to be:

- HIV treatment: $8,011 x 284 = $2,275,124
- Chronic disease: $11,592 x 62 = $718,704
- TB: $30,000 x (15% of 284, or 43) = $1,290,000
- MDR TB: $300,000 x 2 = $600,000
- Total estimated cost: $4,883,828

1) C. Impact of Part A Funding: Funding Mechanisms

(1) **Report on the Availability of Other Public Funding: See Attachment 5 - Availability of Other Public Funding for FY13 and Anticipated for FY14.**

(2)(a) **Coordination of Services and Funding Streams**: Ryan White Part A services are coordinated with other programs and funding streams. During the Part A priority setting and resource allocation process, members of the Priorities Committee were provided information about HIV/AIDS Services, including the "Report on the Availability of Other Public Funding" from the Atlanta EMA HRSA FY13 Grant Application, which summarized the funding available

in the EMA from Federal, State and local sources. An overview, including the source and amount of funding to each broad service category, was provided to the Committee for consideration during the priority setting and resource allocation process to avoid duplication of services, to maximize Part A funding as the payer of last resort, and to ensure continuity of care. The following is a description of the type and scope of collaborative efforts currently in place.

Medicaid: The Georgia Department of Community Health, Division of Medical Assistance, which administers Medicaid, is the largest payer for inpatient care for persons with HIV disease (SFY13-$24,949,937; SFY12-$19,974,005; SFY11-$22,019,950). In the EMA, 3,709 (SFY12-3,519; SFY11-3,180) clients were served in SFY13 at a cost totaling $47,607,249 (SFY12-$47,607,249; SFY11-$46,358,827).[38]

Georgia has **declined** to implement the Medicaid Expansion option under the Affordable Care Act. Due to current strict eligibility guidelines, males with HIV must be disabled before being eligible for coverage. In the EMA, males represent 78% of the total HIV/AIDS prevalence, yet account for only 14% of Medicaid recipients. According to CAREWare data, only 15% of **all** Part A clients received Medicaid.

The State's inadequate Medicaid program increases the burden of care on the Ryan White program. For example, the adult dental benefit is limited to emergency care and primarily dental extractions. There are striking disparities in dental disease by income. The burden of oral disease and its conditions is disproportionately borne by individuals with low socioeconomic status and by those who are vulnerable because of poor general health.[39] In addition, reduced quality of life related to oral health is associated with poor clinical status and reduced access to care.[40] Medicaid coverage for adult dental services has often been the victim of budgetary cuts during periods of fiscal retrenchment. For many low-income, under- or uninsured individuals living with HIV, the Ryan White HIV/AIDS Program is their only source of coverage for oral health care.[41]

During the priority setting and allocation process, the Priorities Committee considered Medicaid funding, the limited services, the restrictive eligibility requirements, and Georgia's refusal to implement Medicaid Expansion, and allocated funding for Primary Care and maintained the FY13 allocation for the Oral Health priority category.

Medicare and Part D: The Part A primary care sites remain diligent in their efforts to enroll clients in Medicare to maximize Part A funds. As with Medicaid, Medicare does not have an adult dental benefit. For 2014, the Part D standard prescription drug benefit as defined by the Centers for Medicare and Medicaid Services (CMS) includes a $310 ($15 reduction) deductible and reductions in the Initial Coverage Limit to $2,850 in total drug costs From this point until catastrophic coverage begins, the beneficiary pays 100% of drug costs. This gap in coverage is commonly referred to as the "donut hole". These costs are decreasing at the same time the coverage for the "donut hole" is increasing. As a result of the Affordable Care Act, beneficiaries will receive coverage and discounts of 52.5% on covered brand name drugs and 28% on covered generic drugs. Even with the reductions in beneficiary costs, enrollment in Medicare Part D presents challenges and compromises many clients' ability to receive and/or afford their ARVs.

[38] Department of Community Health, Office of Planning and Fiscal Analysis, August 2013.
[39] US DHHS. Oral Health in America: A Report of the Surgeon General, Rockville, MD. 2000.
[40] Abel S, Reznik D. New York/New Jersey AETC and Southeast AETC. *Current Trends in HIV and Health Care.* Unpublished presentation to staff of Health Resources and Services Administration, HIV/AIDS Bureau, March 28, 2007.
[41] Surgeon General's Perspectives, Oral Health Care for People Living with HIV/AIDS, Public Health Reports/2012 Supplement 2/Volume 127.

In addition, the state ADAP implemented "TrOOP" (True-Out-Of-Pocket) in 2012 as a cost saving option for clients. CAREWare utilization data for CY12 indicated 16% of clients in the EMA were on Medicare.

The Priorities Committee considered this information in its process and allocated funding for the local AIDS Pharmaceutical Assistance category and maintained the allocation for the Oral Health priority category.

Children's Health Insurance Program: Enrollment in PeachCare (Georgia's CHIP) is available by referral or on-site at all of the primary care sites. The majority of infants, children and youth (l8 and under) receive services at the Grady Infectious Disease Program (IDP). Families are assigned a social worker who assists with the enrollment process.

Enrollment in PeachCare continues to increase (2010-205,990; 2011-207,653; 2012-218,000). A report of the Georgia Budget and Policy Institute indicated that increases in number enrolled could be the result of lingering effects of the recession, increasing awareness of the program, and a policy change that allowed thousands of children of state workers to shift from the state health insurance to PeachCare. Total funding for PeachCare in the SFY14 budget is $79,578,343, a decrease of $18,902,515.

The Priorities Committee considered the level of CHIP funding in its decision to support the ranking and allocated funding for the Primary Care priority category.

Health Insurance Options under ACA: The Priorities Committee was provided a presentation on the impact of the implementation on Part A clients that included a breakdown by FPL of clients eligible for premium tax credits with projected cost of premiums and co-pays.

As a result of this presentation and discussion by the Priorities Committee members, the Health Insurance Program (HIP) was added and ranked as a core service and funding in the amount of $2,200,000 was included in the allocation for FY14.

Veterans Affairs (VA): Clients eligible for VA services typically receive primary care in the VA clinic, but may instead choose to access Part A funded services. Approximately 1% of individuals eligible for HIV services at the VA receive their primary care services outside of that system. Part A funds on-site medical case management services for HIV patients at the VA.

In determining the need for Part A funded primary care, the Committee considered the availability of VA funded primary care and continued to support the ranking and allocation of Medical Case Management.

HOPWA: The City of Atlanta is the recipient of funding for the EMA's HOPWA Program. The Priorities Committee considers HOPWA funding when setting priorities for Part A funding. The Planning Council advises the City of Atlanta in setting priorities for HOPWA funding with the Council's HOPWA Committee being responsible for reviewing applications and making funding recommendations for consideration by the City of Atlanta. During the FY14 priority setting and allocations process, the Priorities Committee was advised that the HOPWA FY13 funding level is $6,613,557.

In considering the amount of available funds in the EMA for housing, the Priorities Committee set Housing as a priority, but did not allocate Part A funds for this priority category. However, the Committee allocated funding for Emergency Financial Assistance under the Support Services category.

CDC Prevention: In Georgia, the Department of Public Health (DPH) is the recipient of the majority of funding through the CDC Prevention Program. The state's Request for Proposals (RFP) for prevention services requires participation on the Part A Planning Council or local consortium. The Planning Council has a designated representative on the Georgia Community

Planning Group (GCPG) who provides reports to the Planning Council. DPH FY13 funding for prevention activities in the EMA is $1,674,839. Funding is set aside for linkage to care activities at health departments located in Fulton, DeKalb, Clayton, Cobb and Gwinnett counties. Enhanced Comprehensive HIV Prevention Program (ECHPP) funding is targeted at three sites serving high risk populations. Part A funds primary care services at these same sites. In addition, four Part A agencies are funded directly by the CDC for a total of $2,075,634. Counseling, testing and linkage services target MSM between 18 and 45, homeless, African American heterosexual males and females and the transgender populations. Activities include linkage to care, evidence-based intervention in clinical and group settings, and case finding. These activities facilitate identifying individuals unaware of their status and promoting linkage to primary care.

Prevention funding for FY12 in the amount of $4,981,734 was directly awarded to the Fulton County Department of Health and Wellness for activities in Fulton and DeKalb Counties including high impact HIV prevention, expanded HIV testing for disproportionately affected populations and linkage to care. Funding has been awarded to three (3) Part A funded sites for linkage services and the potential impact will be an increase in the number of newly identified individuals entering care.

The availability of these services influenced the Committee's decision to rank Primary Care as its highest priority and allocate all MAI funds to Primary Care.

Services for Women and Children: To facilitate access to other programs, eligible women may enroll in the Women, Infants and Children nutrition (WIC) Program at their primary care site. Women and children also have access to Part D funded services.

The Priorities Committee considered the availability of these funding sources along with previous Part A funding to support services for this population and allocated funding to the Primary Care category and the Food and Childcare categories under Support Services.

Other State and Local Social Service Programs: Georgia Division of Family and Children Services programs, including foster care, may be accessed on-site at six of the primary care sites for enrollment in general assistance and food stamp programs. The Supplemental Nutrition Assistance Program (SNAP) saw a 128% increase in cases in Georgia between December 2007 and December 2012. Georgia's record high unemployment and poverty during that time meant more families needed help putting food on the table. Georgia's unemployment rate has declined, but it is still higher than the national average. One in five Georgians does not have sufficient access to food, including more than one in four children.

The Priorities Committee considered these services in determining the need for specific Part A services including Emergency Financial Assistance and Food.

Local, State and Federal Public Health Programs - Part A funds augment funding for services supported by local, state and federal public health programs.

The Priorities Committee considered all other funding in its decision making for the ranking and allocation of each the priority categories.

Local and Federal Funds for Substance Abuse and Mental Health Treatment Services: The core of substance abuse and mental health treatment services in Georgia is funded through the Georgia Department of Behavioral Health and Developmental Disabilities (BHDD). Georgia has a set-aside for services to PLWH in substance abuse treatment funding from the Substance Abuse Mental Health Services Administration (SAMHSA) for HIV/AIDS services through BHDD. The required 5% set-aside for HIV is $3,672,382. Part A funded outpatient and

residential substance abuse treatment programs expand the capacity to address the increasing demand and facilitate access to care and treatment for the dually diagnosed. The DeKalb County Board of Health has an interagency agreement with its local BHDD Community Service Board (CSB) to expand the current level of Part A funded mental health/substance abuse services available by current staff in the HIV clinic. The coordination between the CSB and the HIV clinic reduces service duplication.

The GDPH receives funding from SAMHSA to support the Atlanta Collaborative HIV/AIDS Network for Growth and Empowerment (CHANGE) project which augments current services for mental health and substance abuse services. The Program Coordinator for CHANGE is a member of the Part A Early Identification Workgroup (EIW). All seven organizations funded by the CHANGE Project in the amount of $1,069,187 are within the EMA and five are Part A funded as well. In addition, five agencies are directly funded by SAMHSA; three with Part A funding.

The Priorities Committee considered the data and maintained the rankings and allocated funds for the Mental Health and Substance Abuse priority categories.

Other Ryan White HIV/AIDS Program Funding (Parts B, C, D, and F)

Ryan White Part B and AIDS Drug Assistance Program (ADAP): The Ryan White Part B program, administered by the Georgia DPH, provides care and treatment services. These services include those provided by ADAP and the Health Insurance Continuation Program (HICP). Some agencies or health departments included within the EMA receive Part B funding to provide additional client services (Fulton and DeKalb Counties do not request, nor receive, Part B funding which increases the pool available for the other 16 health districts). These areas coordinate Part A and B funds to provide a comprehensive continuum of care and ensure that a maximum number of clients receive services. Examples of such coordination are seen in Gwinnett County located in the northeastern part of the EMA. The Gwinnett County Board of Health receives Part B funds directly from DPH and contracts with AID Gwinnett, an AIDS Service Organization (ASO) that receives Parts A and C funds. Ryan White funds support the infrastructure for HIV services in this region. Services would be significantly compromised without such coordination, as none of the resources is sufficient to meet the growing demand for services in this region.

Further demonstration of collaboration is demonstrated in the Georgia ADAP. All primary care clients within the EMA are screened for ADAP eligibility. If eligible, applications are submitted to the Georgia DPH to complete the enrollment process. For example, the Georgia DPH contracts with the Grady Health System, which participates in the State's ADAP Contract Pharmacy (ACP) Network. The pharmacy is co-located within the Grady IDP, the largest Part A funded primary care provider. IDP clients within the Atlanta EMA can pick up their ADAP medications at the pharmacy. Additionally, AID Gwinnett piloted the electronic ADAP application. Of the 7,649 active clients in the State ADAP as of March 31, 2013, 5,201 (68%) reside within the 20-County EMA. DPH does not currently have a waiting list.

Prior to FY07, the Atlanta EMA supported the Georgia ADAP with funds in the amount of $1.5 to $1.9 million. In consideration of the overall increase in the Part B ADAP award, Part A funds **were not** allocated to support the ADAP for FY08-FY12 in the base funding range. However, unexpended Part A funds were redirected in FY08-$500,000, FY10-$789,530, FY11-$848,731 and FY12-$300,000 to support shortages in the ADAP. In FY13, Part A funds support the local AIDS Pharmaceutical Assistance (APA) program which provides clients an avenue to access ADAP formulary medications while waiting for final ADAP approval, and covers those

clients who are not taking antiretroviral medications and are, therefore, ineligible for ADAP. Formulary medications are purchased through the HHS drug pricing program.

Similarly, DPH administers the Health Insurance Continuation Program (HICP). This program, funded with Ryan White ADAP dollars, provides eligible clients assistance with third party insurance premium payments. This program currently serves 668 active clients, with 486 (73%) residing within the EMA. By paying the insurance premiums for these eligible individuals, primary health care services are provided by the private sector, allowing Ryan White funds to be used for those with no other resources. All Part A funded medical case managers and agency financial counselors are familiar with the HICP and routinely screen clients for eligibility and referral.

The Priorities Committee considered the estimated ADAP funding for FY14, the elimination of the waiting list, the potential impact of the ACA and allocated funding to the local APA category only.

Ryan White Part C: Seven of the Part A primary care sites are also Ryan White Part C funded recipients. As with all agencies receiving Ryan White funding from multiple sources applying for Part A funds, Part C recipients are required to describe and demonstrate how Part A funds will be coordinated with Part C. Part A funds do not supplant services funded by Part C, or any other funding source. Part A applications must include an itemization of other funding sources by line item for personnel, supplies, equipment, and services.

The Priorities Committee considered the availability of Part C funds in its decision to allocate funding to the Primary Care, local APA, Oral Health, Mental Health and Substance Abuse categories.

Ryan White Part D: The Grady IDP is the Grantee for the Part D program serving metropolitan Atlanta. This project area mirrors the service area for the Atlanta EMA. The Part D project provides funding for women, infants, children and youth (WICY), and funds are contracted to three service providers, including one agency that receives Part A funds. Part D agency representatives are on the Planning Council in order to maximize service provision. The Part D Grantee, through its structure, supports services in the Grady IDP and in the Special OB/GYN clinic of the EMA's largest public hospital where approximately 65-70 medically indigent HIV positive pregnant women are served each year. A social worker from the Grady IDP Family/Youth Clinic provides case management to these OB clients to assure a smooth transition to the Grady IDP Family/Youth Clinic following delivery. Ancillary services, such as WIC, legal services, oral health care, housing placement, mental health services, childcare, and case management are also co-located at the IDP.

Part D supports a program to identify HIV positive Hispanics and provide linkage to care. Individuals identified through this program are referred to primary care throughout the EMA, some of which are supported directly by Medicaid, Part D, or by Parts A, B or C.

The Priorities Committee considered the availability of Part D funds in its allocation process and allocated funding to ensure a comprehensive system of care that includes services for women, infants, children and youth.

Part F - Special Projects of National Significance (SPNS):

AID Gwinnett, a community-based organization in the EMA, received funding for Health Information Technology (HIT) capacity to develop an interface between Cerner (its electronic medical records program) and CAREWare to reduce data entry time through the Provider Data Import process. This process is in its testing phase now with an anticipated completion date of November 1, 2013.

Part F - AIDS Education and Training Centers: The Atlanta EMA is served by SEATEC which conducts comprehensive training for healthcare providers who work in the Atlanta EMA. Instruction focuses on medical management of HIV, ensuring that HHS Treatment Guidelines constitute the core teaching message. SEATEC trainings frequently include Part A funded staff and health care providers associated with other Ryan White programs and other federal and non-federal programs.

SEATEC places special emphasis on training newly-hired medical staff that may have limited experience in HIV medicine in order to enhance their clinical skills. In addition, SEATEC seeks guidance from Part A staff and clinical staff in identifying community clinicians who might benefit from HIV training and informs identified clinicians of training opportunities. SEATEC conducted a statewide training needs assessment.

SEATEC staff are directly involved with the Part A program on an ongoing basis: 1) the Research Project Manager for SEATEC's Research and Evaluation Unit performs analyses of HIV-related resources and needs, surveying both HIV service providers and consumers of services, is a member of the Planning Council and provides support to the Quality Management Committee as needed and 2) the Unit's Research Associate is a member of the Planning Council and its Assessment Committee.

Part F - Dental Reimbursement Programs: The EMA does not receive Dental Reimbursement funding. However, the Council representative for this category is the Director of Oral Health Services for SEATEC and Director of Oral Health Services for the Grady Health System. Services are coordinated and clients are referred to Emory University Clinic for oral surgery that cannot be provided in the EMA's oral health programs.

1) D. Assessment of Emerging Populations with Special Needs

For all cost estimates in this Emerging Population section, the estimated annual cost per client for Core and Support Services in Atlanta's continuum of care is based upon estimated FY14 costs.[4] Whenever possible, data from Attachment 3 were used for the estimated number of PLWHA.

(1) **Population Group: Young African American MSM (15-30 years old)**

Since the onset of the HIV/AIDS epidemic in the United States, AIDS incidence and prevalence has been the highest among MSM.[42,43] Forty seven percent (47%) of PLWHA through 2012 in the EMA were MSM among whom 60% were African American.[2]

Young men who have sex with men (YMSM), defined here as those aged between 15 years and 30 years, are of particular concern. Through 2012 in the EMA, YMSM accounted for 21% of all cumulative cases of AIDS, 31% of all cases of HIV non-AIDS, 25% of all MSM with AIDS and 38% of MSM with HIV non-AIDS.[2]

In 2010 there were 316 YMSM reported, 466 in 2011 (increase of 47% from 2010) and 503 in 2012 (an increase of 8% from 2011). YMSM in 2010 represented 41% of reported MSM, 48% in 2011 and 49% in 2012. In 2010, Young African American MSM accounted for 49% of reported cases in all MSM, 54% in 2011 and 56% in 2012.[2]

The rates for chlamydia, gonorrhea and syphilis among males continue to steadily increase in the EMA. Data from 2011 (latest available from the State) show that 22% of all

[42] HIV risk profiles among MSM-IDU and MFSP-IDU: Results from a national enhanced HIV surveillance system**.** Marissa McGuire et al, 18th Annual Canadian Conference on HIV/AIDS Research, Vancouver, Canada, April 2009.
[43] HIV prevalence, incidence, and related risk behavior among injection drug users upon arrest, San Francisco 1999-2001. Bordelon K, et al. *Int Conf AIDS.* 2002 Jul 7-12; 14: abstract no. WePeC6123.

chlamydia, 36% of all gonorrhea and 35% of primary syphilis cases were among young males aged between 15 and 30 years. African American males accounted for 56% of males with chlamydia, 71% of males with gonorrhea and 89% of males with primary or secondary syphilis.[17] The rates of STIs and HIV positivity were highest among African American males.

(a) **Unique Challenges Presented**

YMSM are members of all communities, all races and ethnicities and all strata of society. They do not believe they will contract any disease, as is typical of people of that age group. The unique challenges presented by this segment include racism, homophobia, poverty, and lack of access to health care services. African American males are more likely than White males to receive a diagnosis of HIV infection in the late stages, often when the infection has progressed to AIDS, which suggests that they are not accessing testing or health care services early in their infection when treatments might be more effective.

In *The Consumer Survey*, a lack of transportation was given as the reason for not seeking testing or treatment of their HIV disease by 48% of YMSM (an increase of 34% from the previous year).[4]

The stigma associated with homosexuality may inhibit some YMSM from identifying themselves as gay or bisexual, even though they have sex with other men. Some men who have sex with men and with women do not identify themselves as gay or bisexual. Research suggests that elevated rates of STIs and undetected or late diagnosis of HIV infection may contribute to higher rates of HIV infection among African American MSM.

Data from the 2011 Georgia HIV Behavioral Surveillance found that 38% of infected MSM were unaware of their infection status; 45% of African American MSM did not know their status compared to 18% of White MSM; 59% of infected MSM aged 18 and 29 did not know their HIV status.[44] In a survey of IV drug using MSM, 29% reported they did not seek HIV testing as they perceived themselves at low risk despite moderately high levels of STI infections. Twenty-five percent (25%) were afraid to learn their status and 9% said they did not have the time for testing. Interestingly 1% described their dislike of needles as their reason not to be tested.[45]

Additional information suggests individuals, especially youth, who are identified as seropositive for HIV tend to undertake high risk activities at a higher rate than those who tested negative for HIV. These data are based on other STI infections contracted by participants in this study before and after their HIV test status is determined.[46] In another study, youth who received any form of medical care in the previous year of the study were more likely to have had an HIV test. However, most young people do not attend medical facilities at that age and need to rely on education or peer groups to suggest they need testing. In addition, an individual may not consider themselves at risk as they may not know the risk factors of their partners. This includes those forced to have sex without a condom, having sex and drug use simultaneously and forced sex with partners they may not know that well.[47] This supports encouraging YMSM requesting their partners be tested also.

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[44] 2011 Focus Population Report. Georgia HIV Behavioral Surveillance, HIV/AIDS Epidemiology Section, Georgia Department of Public Health, 2012.

[45] Risk Prevention, and Testing Behaviors Related to HIV and Hepatitis Infections – National HIV Behavioral Surveillance System: Injecting Drug Users, May 2005-2006, HIV Special Surveillance Report.

[46] HIV Testing and Risky Sexual Behavior. Gong E, September 2010.

[47] Correlates of HIV Testing History Among Urban Youth Recruited Through Venue-Based Testing in 15 U.S. Cities. Straub M, et al,.Sexually Transmitted Disease, 2011:38:8;691-696.

Of particular concern is the trend towards younger males being reported with HIV infection over the last two years. These young males have not been subjected to the same intensity of HIV prevention education as older males and they also see HAART as a "cure" for HIV. The obvious fact that people with HIV infection are now living much longer and healthier lives than previously tends to render it as less of a threatening disease and more like an infection that can be cured with treatment.

Young African American MSM are less likely than Young White MSM to live in gay-identified neighborhoods. Therefore, prevention and treatment programs directed to gay-identified neighborhoods may not reach these YMSM.

Finally, as expressed in the National HIV/AIDS Strategy (NHAS), "**The United States cannot reduce the number of HIV infections nationally without better addressing HIV among gay and bisexual men**".[48]

(b) **Service Gaps**

Service gaps identified through *The Consumer Survey*. Greatest needs were:

1. Oral health (preventive {22%}, emergency {23%}and general treatment {23%});
2. Food and Nutrition services (food vouchers {41%}, supplements {34%} and food pantry {28%});
3. Counseling services (peer counseling {25%}, mental health {23%}, benefits {21%} and legal services {28%}).

Without peer counseling services for example, YMSM are less aware of their disease implications, other support services available and locations of clinical services. With the influx of YMSM from the prison system with such a high concomitant need for mental health and psychiatric services, these gaps in services become effectively larger.

(c) **Estimated Costs Associated with Delivering Services to Young African American MSM**

Estimates for the cost of treating a person with HIV disease were calculated to be $8,011[49] per client per year. The estimated number of YMSM who would require services in FY14 was calculated by taking the number of PLWHA who were African American MSM in the 15-30 age group (773); to this were added the proportionate number of unaware PLWHA as calculated per CDC guidelines for EIIHA (205) for a total of 978.[50]

YMSM Living with HIV and AIDS, 2012		
	Total	**YMSM (11%)**
PLWHA, YMSM	773	773
Unaware	8,365	205
		978

Using this calculation there are likely to be 978 YMSM/IDU PLWHA requiring Part A services in FY14. Based on this calculation, the estimated cost of providing care for PLWHA in this population is: 978 * $8,011 = $7,834,758.

(2) **Population Group: Women of Childbearing Age, 15-49 Years of Age**

Women accounted for 27% (344) of newly reported AIDS cases in the EMA in 2012, 21% of PLWHA and 25% of all clients receiving Part A services in the EMA.[2] Nearly two-

[48] National HIV/AIDS Strategy for the United States, The White House Office of National AIDS Policy, July 2010.
[49] From cost figure table in Section **1)B**.(*1)* of this application.
[50] CDC calculation methodology: (0.21/0.79)x(number of population involved)=unaware members of that population.

thirds (61%) of all women PLWA are aged between 15 and 49 years. The proportion of PLWHA who are women in this age group has increased from 60% in 2009 to 65% in 2012. Women aged between 15 and 49 accounted for 61% of all women PLWA in the EMA, but this increased to 69% among women PLWH. Among women aged 15-49 years, 79% were African American PLWA and 73% among PLWH.

Most adult and adolescent women PLWA in whom high risk activities were documented, listed heterosexual activity as their risk factor (66%, 960 cases, in the EMA) and most others reported injecting drugs (29%, 425 cases, in the EMA). Among PLWHA women of childbearing age 58% were HET (555 cases).

African American women account for 78% (5,140) and White women account for 4% (533) of all female PLWHA in the EMA in 2012. Among women of childbearing age, 64% (3,281) were African American and 6% (327) were White.[2]

The presence of STIs greatly increases the likelihood of acquiring or transmitting HIV infection. The EMA is ranked 6th in the nation among SMSA's for gonorrhea. Women account for 45% of cases of gonorrhea, 71% of chlamydia cases and 15% of syphilis cases.[17]

(a) Unique Challenges Presented

The challenges presented to women include discrimination, low socioeconomic status, poverty, and lack of insurance. In addition to the challenge of living with HIV, women also face challenges of domestic abuse, maternal health issues, and are often the primary caregivers for children and aging parents. HRSA's HIV/AIDS Bureau's Client Demonstration Project found that among women, receipt of medical care services, emergency financial assistance, housing assistance, or transportation services was predictive of continuing receipt of services in the following year. This finding indicates that many women are living in poverty and have a continuing need for support services. Among HIV positive women, psychological distress poses a significant barrier to care. In one study, 31% of women who tested positive for HIV delayed accessing care for three months or longer because of fear, depression, and anxiety about their serostatus. Of the 2,000 women enrolled in the National Institutes of Health Women's Interagency HIV Study nearly 50% reported a history of sexual abuse and 60% were victims of domestic violence.[51]

In addition, women are at risk based on the activities of the men with whom they are having sex since most female HIV infections are transmitted through heterosexual activities. African American women are more at risk than White due to the higher drug use by their partner. This also applies to Hispanic women.[52,53]

(*b*) Service Gaps

Gaps in services for women of childbearing age documented in *The Consumer Survey* included the following:

1. Food and Nutrition services- 45% needed food vouchers, 35% needed nutritional supplements, 21% needed food pantry, 15% needed nutritional counseling;
2. Oral health care- 35% needed at least one of preventive, emergency or treatment care;
3. Other services-17% needed legal services and 15% psychiatric care.

All services, including on-site childcare and a Pediatric Care Unit, are provided at the Grady IDP. The centralized case management system facilitates referrals to other programs such as housing, financial and food assistance programs. Through the Ryan White Part D program,

[51] HRSA Fact Sheet: Women & HIV/AIDS.
[52] National HIV/AID Strategy for the United States, The White House Office of National AIDS Policy, July 2010.
[53] CDC, HIV/AIDS Surveillance in Injection Drug Users (through 2007) Slide set.

Grady Hospital's Obstetrics (OB) program has resources in place to provide prenatal care to uninsured HIV positive pregnant women.

(c) Estimated Costs Associated with Delivering Services to Women of Childbearing Age

Estimates for the cost of treating a person with HIV disease were calculated to be $8,011 per client per year. The estimated number of childbearing women who would require services in FY14 was calculated by taking the number of PLWHA who were female in the 15-49 age group with a 3% increase (4,424); to this was added the proportionate number of unaware PLWHA (1,176).[50]

Women of Childbearing Age Living with HIV and AIDS, 2012		
	Total	**Childbearing Women**
PLWHA	31,469	4,424
Unaware	8,365	1,176
		5,600

Using this calculation there are likely to be 5,600 women of childbearing age who are PLWHA requiring Part A services in FY14. Based on this calculation, the estimated cost of providing care for the number of living AIDS cases in this population: 5,600 * $8,011 = $44,861,600.

(3) Population Group: Aging PLWHA, 50 Years of Age and Older

PLWHA are living longer. The number living in the EMA who are aged 50 years or more has increased from 8,561 in 2010 to 10,428 in 2012, an increase of 22%. The majority (67%, 6,969) are PLWA. Diseases associated with people aged over 50 will now require treatment. It is estimated that 9.5% of the EMA general population has diabetes (which increases to 23% in those aged over 60),[54] 23% has some form of cardiovascular disease (that includes coronary artery disease, stroke, peripheral vascular disease, hypertension and heart failure)[55], 18%, rising to 49% of those aged greater than 65, have arthritis or other rheumatic diseases[56,57] and 3% have one form or another of cancer.[58] Costing of the care for PLWHA who have one or more coexisting conditions is difficult and is reliant on national data, some of which can be localized to the state level.

(a) Unique Challenges Presented

Virtually all medical and social care sought and received by PLWHA has been provided in infectious disease offices or clinics. These same services will continue but in addition, services of other specialties will be needed to deal with their chronic diseases. These will include Cardiologists, Endocrinologists, Gastroenterologists, Orthopedists, Ophthalmologists, Oral Surgeons and Dentists. Most PLWHA have no insurance (56% of clients at Ryan White Part A sites) or limited public insurance (33% Medicaid, Medicare or other public assistance) to seek care from these other specialties and will rely on their current infectious disease specialists to manage all their care.

[54] American Diabetes Association, September 2010.
[55] American Heart Association, September 2010.
[56] National and State Medical Expenditures and Lost Earnings Attributable to Arthritis and Other Rheumatic Conditions. MMWR 2007; 56(1): 4-7.
[57] Arthritis Prevalence and Activity Limitations -- United States, 1990. MMWR: 43(24): 433-438.
[58] Healthy People 2010, November 2000, Centers for Disease Prevention and Control and National Institutes of Health.

In addition to ongoing chronic disease care, the aging population is sexually active. It is estimated that almost three quarters of people aged between 50 and 65 are sexually active and half between 65 and 75 years. In addition, 62% of men and 78% of women in this age group had not discussed sexual activity with their physician. Thus there is an educational need, not just of physicians and other caregivers, but also of the general population about the risks of unsafe sexual activities.[59]

(b) **Service Gaps**

The Consumer Survey identified a number of service gaps including:

1. 50% of clients were unable to see their physician in a timely manner which was especially true among those aged over 50 years.
2. Lack of appropriate specialty care was the highest ranked barrier when looking at capacity to provide care.
3. Difficulty in managing paper work was considered a barrier to care in this age group.
4. 31% have problems with transportation.

(c) **Estimated Costs Associated with Delivering Services to Older PLWHA**

Estimates for the cost of treating a person with HIV disease solely for their HIV treatment were calculated to be $8,011 per client per year. The estimated number of older PLWHA who would require services in FY14 was calculated by taking the number of PLWHA who were aged 50 or more in 2012 and adding 3% (10,741); to this were added the proportionate number of unaware PLWHA who were aged 50 or more (2,783).

Aging PLWHA, 2012		
	Total	**Older PLWHA**
PLWHA	31,469	10,741
Unaware	8,365	2,783
		13,524

Using this calculation, there are likely to be 13,524 older PLWHA requiring Part A services in FY14 (Attachment 3). Based on this calculation, the estimated cost of providing care to PLWHA in this population is: 13,524* $8,011 = $108,340,076. One method of developing a cost of managing the older population with different chronic diseases relies on the published data of cost of managing each disease for one patient for one year. Using these data, the table below provides a crude estimate of this cost:

Disease	**Cost/patient/yr[60]**	**Total Aged PLWHA**	**Affected PLWHA**	**Fiscal cost**
Diabetes	$4,640	13,524	3,110*	$14,430,400
Cardio-Vascular	$1,533		3,110*	$4,767,630
Cancer	$3,667		406**	$1,488,802
Arthritis	$1,752		2,821***	$4,942,392
Total Estimate	**$11,592**			**$25,629,224**

*23% of aged PLWHA, **3% of aged PLWHA, ***25% of aged PLWHA up to 65 plus 49% older than 65 years

This is a gross underestimate as most of these chronic diseases occur with greater frequency in the older population than in the general population. Costs of disease management

[59] A Study of Sexuality and Health among Older Adults in the United States.
Stacy Tessler Lindau, M.D., M.A.P.P., et al, N Engl J Med 2007; 357:762-774 August 23, 2007.

[60] Based on a range of estimates and using roughly the median of those estimates in published articles.

increase with age and are not accounted for in this crude estimate. For example, arthritis affects about 18% of the general population, but this rises to 49% if the population is aged over 64 years. That would drive the cost of care as calculated in the above table from $4 million to $9 million approximately. In all the diseases listed, the incidence of new cases will increase with advancing age, as will the costs. However, the general trend indicates treatment of aging PLWHA will cost, at a minimum, half as much again as the cost of basic HIV treatment alone (an additional $11,592/PLWHA/yr), and maybe as much as 4 times the basic HIV cost.

(4) Population Group: Transgender

Although the number reported as transgender is small at 73 of cumulatively reported cases of HIV in the EMA through December 2012, it is increasing. There were 111 HIV infected transgender clients being treated in the Ryan White Part A clinics in 2012. This illustrates the challenge in identifying the transgender population. The majority was African American (105, 89%), MSM (94, 80%), had a median age of 43.5 years (median of all other clients attending Ryan White Part A sites was 44.5 years) and had a median income of $20,367 (100% of 2013 FPL was $11,490 for household of one, 300% FPL-$34,470 and $15,130 for a household of two, 300% FPL-$45,390). The majority (96, 86%) lived alone and 10% lived in a household of two people. Eighty had no health insurance (72%) and 21 (19%) had public insurance (Medicaid, Medicare, Champus, VA). Fifteen percent had syphilis and 10% had hepatitis B and/or C.

(a) Unique Challenges Presented

Discrimination is a major issue for transgender individuals. Reports suggest this to be as high as 80% in the work place and publically in 62%. Harassment is high in schools (83%) and in the police and court system (34%).[61] These two factors have combined to lead 40% of transgender people to consider suicide.[62] There is high unemployment (21%) and homelessness (23%).[63] Among the homeless, up to 20% have been refused shelter. Receipt of medical care is difficult as health care providers themselves discriminate (16% of transgender patients were refused care) and providers are generally unaware of the specific needs, both medical and psychological, of this population. Transgender individuals have a higher risk of thromboembolism and liver abnormalities if taking estrogen therapy (male to female). Similarly there is a higher risk of heart disease, endometrial hyperplasia and cancer from androgen therapy (female to male).[64] Prostate cancer is still a risk in the male to female transgender if hormones are taken but surgery is not completed. Endometrial cancer is still a concern if surgery was not undertaken in female to male transgender individuals. Sexual identity on identification documents is often poorly completed with one third not completing their documentation.

(b) Service Gaps

The Consumer Survey data revealed a number of service gaps including:

1. 63% were not able to obtain basic oral health care;
2. Food pantry services were needed but not provided in 50%, nutritional supplements not provided in 38%, food vouchers not provided in 31%;
3. Counseling in benefits (14%), substance abuse services (14%) and psychiatric consultation (13%)

[61] National Transgender Discrimination Survey, National Center for Transgender Equality and the National Gay and Lesbian Task Force, Georgia report, June 2013.
[62] Deaths: Final data for 2002. National Vital Statistics Report, 53 (5), 2005-1120, table 1, p 108.
[63] US Department of Housing and urban Development, US Housing market conditions, 2nd quarter, 2009.
[64] Health care problems of lesbian, gay, bisexual and transgender patients. West J Med. 2000 June; 172(6):403-408.

(c) Estimated Costs Associated with Delivering Services to Transgender

Estimates for the cost of treating a person with HIV disease solely for their HIV treatment were calculated to be $8,011 per client per year. The estimated number of transgender PLWHA who would require services in FY14 was calculated by taking the number of PLWHA who were transgender in 2012 (111); to this were added the proportionate number of unaware PLWHA transgender[50] (23 cases) for a total of 134. Using this calculation, there are likely to be 134 transgender PLWHA requiring Part A services in FY14 (Attachment 3). Based on this calculation, the estimated cost of providing care for the PLWHA among transgender patients would be 134* $8,011 = $1,073,474.

Transgender PLWHA, 2012		
	Total	**Transgender PLWHA**
PLWHA	31,469	111
Unaware	8,365	23
		134

1) E. Unique Service Delivery Challenges

In addition to the issues previously mentioned, there are other factors which contribute to the costs and complexity of providing services in Georgia and the EMA.

Population Growth: Over the next two decades, between 2010 and 2030, Georgia's population is projected to grow by an additional 4.6 million people. According to the current projection, Georgia's population will increase by 46%, from 10.1 to 14.7 million people by the year 2030. Although the growth rate for each decade of this period (21%) is lower than the rapid growth rate experienced during the 1990s, it is similar to the pace of growth posted during the most recent decade (2000-2009).[65] Domestic migration is a primary source of Georgia's population growth and more than a quarter million international migrants moved to Georgia during the period 2000-2009.[66] While all regions of the state are expected to grow, the Atlanta metropolitan area is projected to remain the most densely populated portion of the state, with two out of 5 (43%) Georgian's projected to be living in the 10-County Atlanta Regional Commission Area by 2030.[67] Additionally, the state is experiencing a rapid growth in the number and percentage of residents 65 and older. Older populations typically place increased demand on healthcare services. Between 2000 and 2030, Georgia is projected to add 1.1 million people age 65 and older, an increase of 143%, which more than doubles the current population in this age group. With this expected population growth, Georgia, and Atlanta in particular, must expect to face substantial increases in demand for healthcare services.

Physician Shortages: According to a study commissioned by the Georgia Health Sciences University, Georgia has fallen behind in training physicians and is now scrambling to make up for the deficit. Without immediate statewide cooperation in expanding medical education and residency programs, the state may never again have an adequate supply of physicians. For too long Georgia has relied on out of state and international physicians to make up for the lack of Georgia-trained doctors. Without changes in the state's medical education system, Georgia will rank last in the United States in physicians per capita by 2020.[68] Furthermore, according to the

[65] Georgia 2030 Population Projections, Office of Planning and Budget, March 12, 2010.
[66] Ibid.
[67] Ibid.
[68] Recent Studies and Reports on Physician Shortages in the US, May 2011, Center for Workforce Studies, Association of American Medical Colleges.

CDC, through 2011 Georgia ranked 6th in the total number of cumulative AIDS Cases in the U.S. However, data from the American Academy of HIV Medicine indicate that Georgia has 41 certified HIV specialists statewide, ranking 11th among the top cities.

Dentist Shortages: *A*ccording to the HRSA, as of August 16, 2012 there are 4,406 Dental Health Professional Shortage Areas (HPSA) with 43.8 million people living in them. Nationally, it would take nearly 9,000 dental practitioners to meet their need. Georgia ranks near the top of the list with 141 HPSA designations, requiring more than 240 practitioners needed to meet the needs of nearly 1.1 million (estimated) underserved people within the HPSA. As of 2009, Georgia ranks 48th in the US with 56.2 dentists per 100,000 population, a full 30% below the national rate of 80.7/100,000. Nearly 1 in 7 counties in Georgia has no dentist, while 6.9% have only 1 dentist. The Georgia Health Sciences University, the only dental school in Georgia, graduates enough dentists to only fill 1/3 to 1/2 of the annual replacement need of dentists for Georgia.[69] Despite recent upward trends in enrollment, per capita enrollment has declined, and much expansion is required to meet Georgia's growing need for dentists. Georgia needs to fill an average of 160 dental positions per year.[70]

AIDS in the South: Half of all new infections in the US are in the South, although the region has only a little more than a third of the country's population, according to the CDCDC. The South also has the highest death rate due to HIV. The disproportionate number of cases in the South has many causes: widespread poverty, a shortage of health care, a lack of HIV testing and education, a shortage of accessible medical specialists for the many who live in small rural areas and a persistent prejudice by many in the Bible Belt against homosexuals, the group most affected by HIV/AIDS. The stigma surrounding AIDS remains a key reason that the South is the epicenter of new HIV infections in the United States.[71]

Addressing stigma, especially in the South, presents many challenges. The NHAS includes a number of useful approaches for reducing HIV stigma and discrimination, including engaging communities to affirm their support for people living with HIV and promoting the leadership and visibility of HIV positive people. Stigma-reduction efforts have historically been relegated to the bottom of AIDS program priorities. Innovative approaches to confront stigma head-on, including leveraging social media, have been launched in recent years. The CDC's *Let's Stop HIV Together* campaign uses social media and traditional advertising to give a voice to people living with HIV from all walks of life. *Greater Than AIDS* is a multi-faceted collaboration of community, private and government partners. The Deciding Moments segment of the campaign is a photo-sharing effort that acknowledges that people from all walks of life make daily decisions that impact their risks for contracting HIV. And CDC's *Testing Makes Us Stronger* campaign targets African American gay and bisexual men who are getting hit particularly hard by the epidemic. While much work remains, these are examples of efforts to confront the very real and pervasive stigma that lives on, especially in the South.

Implementation of the Affordable Care Act: Historically, people living with HIV and AIDS have had a difficult time obtaining private and affordable health insurance and have been particularly vulnerable to insurance industry abuses. Consistent with the goals of the NHAS, the Affordable Care Act (ACA) makes considerable strides in addressing these concerns and advancing equality for people living with HIV and AIDS. However, here in Georgia, the implementation of the ACA is not without challenges.

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[69] Kaiser Foundation (2010). Statehealthfacts.org Number of Dentists, 2009.
[70] Georgia Department of Labor: Long-Term Occupational Projections, Statewide, 2006-2016.
[71] Washington Post, David Kohn, July 20, 2012.

Challenge 1: Lack of Medicaid expansion: Georgia ranks near the bottom of all states when it comes to access to health coverage. Nearly 2 million Georgians lack health coverage, which is almost 20% of the state's residents. Under the ACA, states have the option to create a new category of eligibility for Medicaid to cover low-income individuals and families, financed almost entirely with federal dollars. At the present time, Georgia's governor has opted not to expand Medicaid. Nearly 600,000 people would gain health coverage under this expansion (Cover Georgia). Of these 600,000 people, most are working adults who do not have coverage through their jobs. At the local level, analysis of the Atlanta EMA's 2012 Ryan White Data Report suggests that 4,548 of the 13,007 people served would have incomes qualifying them for Medicaid coverage. Without Medicaid expansion, these individuals will likely not have access to the financial resources, including federal tax credits, to purchase insurance through the Health Insurance Marketplace and will remain uninsured and dependent on the Ryan White Program.

Challenge 2: Planning in a time of uncertainty: The State of Georgia has decided against establishing a State-run Health Insurance Marketplace, instead relying on the Federal Government to establish the Marketplace. In doing so, planning for the insurance needs for PLWH has been difficult for a variety of reasons. For example, at the time of this grant application, the costs associated with premiums, co-payments, and out-of-pocket deductibles remain unclear. There is also concern among PLWH that the Ryan White program itself is ending, especially considering that the legislation itself expired on September 30, 2013. The Atlanta EMA has taken a proactive approach to address these, and other, concerns.

- ACA Implementation Study: To address these challenges, the Grantee partnered with the Georgia Health Policy Center at Georgia State University to conduct a study to provide information on how other EMAs are preparing for the implementation of the ACA. The study focused on 3 main objectives:
  - Survey comparable EMAs to determine how they are preparing for the ACA
  - Assess the current Atlanta continuum of care and its ability to bill third-party payers
  - Evaluate Non-Ryan White programs and their networks
- Health Reform Symposium: Additionally, the Grantee hosted a Health Reform Symposium in August 2013 to discuss the potential impacts on the EMA. The Grantee partnered with the Andrew Young School of Public Health, Georgia State University, the Planning Council, Ryan White Consumers, and State of Georgia representatives, as well as other key stakeholders, to discuss concerns and issues regarding the implementation of the ACA. The symposium will also serve as the springboard for a community-wide discussion(s) to assist consumers and service providers navigate the new health care environment.
- Consumer Education: The Atlanta EMA is developing consumer education tools that will guide clients through the process of determining how the ACA may impact their healthcare. These tools will guide clients to the resources necessary to enroll, if eligible, into the Health Insurance Marketplace.
- Consumer Town Halls: The Atlanta EMA will be hosting a series of ACA Consumer Town Halls. The purpose of these events will be to provide information, dispel myths (especially regarding the Ryan White Program), and guide clients through a new health environment. Additionally, many of the Part A-funded health departments and community-based organizations have or are hosting similar events on a localized level.
- Technical Assistance to Service Providers: Service providers throughout the Atlanta EMA have been providing peer-to-peer technical assistance to assist each other enroll as a provider with the insurance companies that have applied to participate in the Health Insurance

Marketplace. It is critical that service providers have the ability to participate in the Marketplace to ensure continuity of care for clients. Additionally, each service provider must have the ability to accept insurance reimbursements for newly-insured clients. This new revenue will help offset potential reductions in other funding as well as potentially increase the number of clients a service provider can support.

- Health Insurance Program: The Planning Council prioritized and allocated funding for a NEW service. Beginning in FY14, low-income clients who have private insurance via Health Insurance Marketplace will be able to access financial assistance with annual premiums, co-payments, and out-of-pocket deductibles. The Atlanta EMA recognizes that many clients with lower incomes will have difficulty paying their portion of the insurance premiums, co-payments, and/or deductibles. To reduce the likelihood that these clients drop out of care due to financial hurdles, the Ryan White Part A program established this new service. Determining the priority and allocation for this service was challenging in that 1) it is a new service with no historical data, and 2) the number of clients requesting support in the first year remains unknown. The Priorities Committee will reconvene early in FY14 to review utilization and financial data and make recommendations as necessary. The Priorities Committee also had the foresight to increase the allocation for case management. It is anticipated that in FY14, many clients may require additional support navigating the new health environment. Case managers will be able to provide this support and an increase is expected in the number of clients accessing both Medical and Non-Medical Case Management.

1) F. Impact of Decline in Ryan White HIV/AIDS Formula Funding

(1) The EMA did not experience a decline in formula funds.

(2) Not Applicable.

1) G. Unmet Need

(1) **See Attachment 6**

(2) **Process for updating the Unmet Need Estimate.** The unmet need estimate was updated to include persons living with AIDS (PLWA) and persons living with HIV/non-AIDS (PLWH) in the Atlanta EMA as of December 31, 2012. The unmet need estimate includes PLWHA as a whole and the subgroups of PLWA and PLWH separately. The data used for the unmet need estimate are derived from eHARS and Laboratory Report Database information provided by the Georgia Department of Public Health's Epidemiology Section. Reported cases in eHARS were matched to reports in the Georgia Laboratory Report Database. The Epidemiology Section also conducts a match of HIV/AIDS surveillance data with the National Death Index, a policy that was first instituted in 2012. All non-reported cases had documented positive Western Blot tests. The framework used for the unmet need estimate is based on the methodology prepared by the University of California, San Francisco as recommended by HRSA.

(3) **Percent of Unmet Need for PLWA and PLWH for CY10, 11 and 12 and trends in the Unmet Need percentages:**

Unmet Need	CY2010	CY2011	CY2012
PLWA	9,524 (58%)	7,142 (43%)	7,727 (41%)
PLWH	6,383 (53%)	5,143 (43%)	6,964 (46%)

The table shows a 15% decrease in the percent of PLWA who did not receive HIV medical care between CY10 and CY11. That percent decrease was lower between CY11 and CY12 (2%), but actually reflects an increase of PLWA not in care. A 10% decrease in the percent of unmet need for PLWH is evident between CY10 and 11. However, there is a slight increase between CY11 and CY12 of 3% with 6,964 PLWH not in care.

The large decreases in percent of unmet need for both PLWA and PLWH between CY10 and CY11 is in part due to the recent efforts by the DPH Epidemiology Section to conduct HIV/AIDS surveillance data matches with the National Death Index. This practice, recently instituted in 2012, has had a clear impact on the overall cases included in the unmet need estimate, providing further accuracy. The increase in cases between CY11 and CY12 can be attributed in part to this effort, but is also the result of further data maintenance conducted by the DPH Epidemiology Section by addressing the back log of data entry and implementing electronic laboratory reporting at many more sites. As of December 31, 2012 there were **18,463 PLWA** and **15,197 PLWH**. Efforts of the DPH Epidemiology Section allowed for more accurate data to be utilized by the EMA in its planning and allocation processes.

(4) **Unmet Need trends are reflected in planning and decision making.** The Priorities Committee of the Atlanta EMA Part A Planning Council reviewed the unmet need estimate during the data collection and review phase of the FY14 priority setting and resource allocation process. This year, the unmet need estimate was used to determine the possible impact of new clients entering the Part A continuum of care due to increased and coordinated linkage efforts being implemented by the GDPH in the EMA allocations to four Part A funded sites. The Committee created a new core service category, Health Insurance Program (HIP), to cover the co-pay and premium costs related to patients moving into the Health Insurance Marketplace as the Affordable Care Act takes full effect.

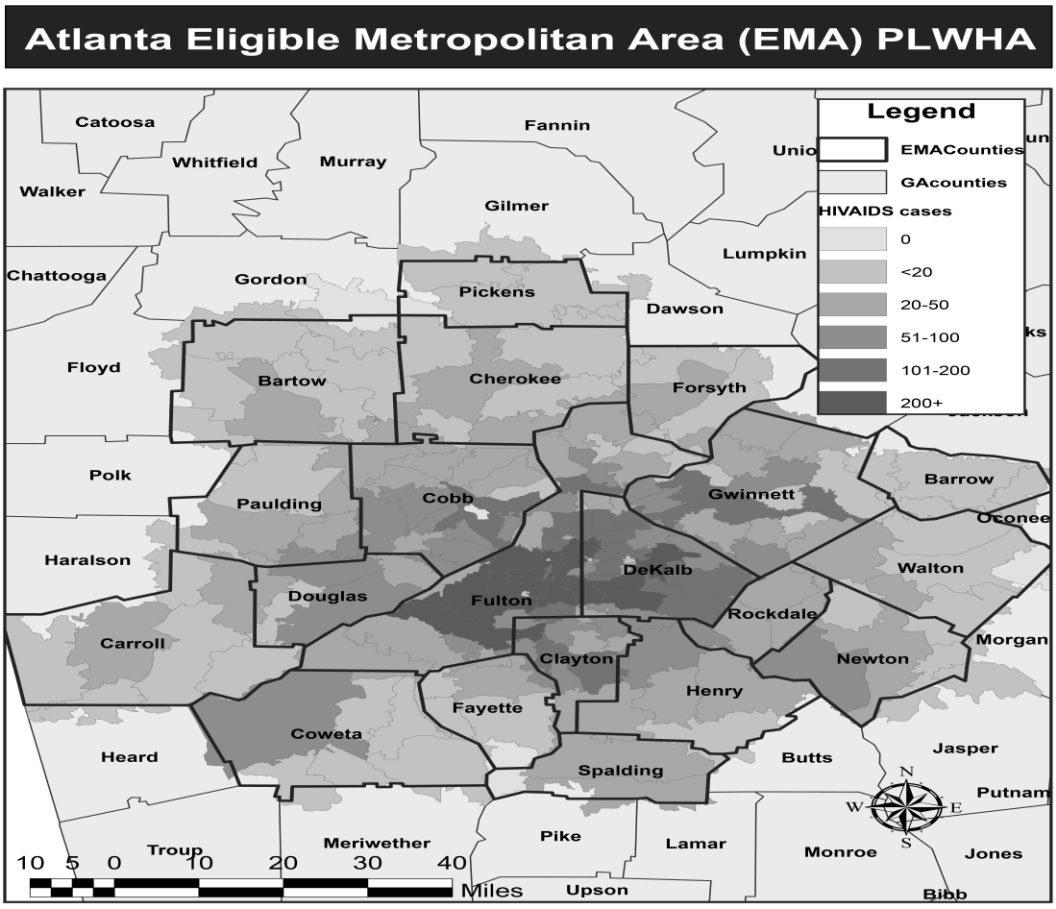
(a) **Demographics and location of people who know their HIV/AIDS status and are not in care:**

Demographics: Of the **14,691** PLWHA identified as being aware of their status but not in care, 11,537 (79%) are males; 9,661 (66%) are African American; 823 (6%) are Hispanic. A total of 3,022 (21%) are females and of these, 123 (4%) are women of childbearing age (between 15-49 years). MSM continue to make up the highest risk group (40%) and the primary age group was 40-49 (31%).

Location: Of the EMA's population, 67% reside in the five most urbanized counties: Clayton, Cobb, DeKalb, Gwinnett and Fulton. These five counties are also home to 91% of all PLWHA with an unmet need. Two of these five counties, Fulton and DeKalb, are home to 73% of PLWHA with an unmet need.

An analysis of zip code data for living cases and unmet need at the end of December 2012 identified 258 zip codes with an unmet need. Of these 258 zip codes, 124 zip codes indicated an unmet need of < 10 persons. Of the remaining 134 zip codes, 65 (49%) had unmet need rates between 50% and 64%. The African American Outreach Initiative (AAOI) targets the zip codes with the highest unmet need through advertising and volunteer recruitment activities. Additionally, primary care sites actively contact clients who have fallen out of care and re-

engage them in care. Zip code data have been mapped (see table below) along with agency locations to assure that services are available to the populations at highest risk. The Planning Council's Assessment Committee used unmet need data in a report developed to identify and locate PLWHA with disparate health outcomes within the 20-County EMA. The report found that the five zip codes with the most severe disparate health outcomes, such as hospitalizations, ER visits, instances of opportunistic infections, corresponded to the zip codes with the highest number of PLWHA with an unmet need. The zip codes are concentrated in the high HIV prevalence areas of Fulton and DeKalb Counties.



(b) **Trends in the past 3 years of unmet need data reflect** an increase in the numbers of PLWA with unmet need between CY11 and CY12 (from 7,142 to 7,727, a 7.6% increase). Due to the introduction of matching cases with the National Death Index and other data maintenance efforts, there was a significant drop from CY10 (9,524) to CY11 (7,142). The Atlanta EMA has seen an increase in the total number of PLWH over the year period from 12,004 in CY2010 to 15,197 in CY2012. The increase can be attributed to various data improvement procedures implemented by the DPH Epidemiology Section, however prior to those efforts; there was a steady increase in PLWH cases. Between CY11 and CY12, there was also a significant increase in the number of PLWH not receiving primary care, from 5,143 to 6,964 (26%). For CY12, the overall unmet need percentage for PLWHA is 43%, the same as in CY11 and a decrease from the 56% calculated for CY10.

(c) **Methods used to assess service needs, gaps, and barriers to care for people not in care** are the focus of the EMA's comprehensive consumer survey data collection that is done every 3-4 years. The most recent consumer survey was completed in 2011, with additional data on transgender and Hispanic/Latino consumers collected in 2012. In order to establish histories of patient adherence to primary medical care, survey respondents were asked if they had ever dropped out of care for more than one year since they first entered care for their HIV disease. Of 715 respondents, 156 (22%) had experienced being out of care at least once since becoming HIV infected and receiving treatment. The sub-population was predominantly male (71%) and African American (71%). The survey also assessed service use, needs and gaps in services for all consumers receiving Part A services. The Atlanta EMA has just completed a client satisfaction survey with over 1,400 consumers. The data are being analyzed to determine if there are any system or program challenges identified that could negatively impact clients remaining in care.

(d) **Efforts to find people not in care and link them to primary care:** The Atlanta EMA is engaging in efforts to find people not in care and link them to primary care in several ways. The EMA is examining unmet need for HIV care among subpopulations and working with agencies that target those subpopulations to enhance existing outreach efforts. Part A is working with Part B, the Counseling, Testing, and Linkage (CTL) program, and the Fulton and DeKalb High Impact Prevention Program (HIPP) to enhance linkage to care for newly identified positive individuals into care. The EMA will continue to work on identifying and addressing barriers that clients face in accessing primary care services. To address reported information barriers, the EMA will use the medical case management screening process to provide clients with information about available services through on-site peer counseling, medical case management services along with sharing of information with the Consumer Caucus. As additional PLWHA are brought into primary care, the Council will evaluate the impact on the continuum to ensure the availability and accessibility of comprehensive services. For FY14, the EMA has requested $75,000 to continue the AAOI to bring HIV positive African Americans into care.

Primary care services include treatment adherence and health education/risk reduction counseling as standards of care. Disease status was also considered in allocations, specifically looking at the different levels of service utilization based on the progression of HIV disease. The Council recognized there would be a corresponding need for allocations to other core services which facilitate access to and retention in care including Medications and Oral Health, Substance Abuse, Mental Health, Medical Case Management and support services including medical transportation.

Unmet Need results supported the continuation of currently funded components of the care system including: activities to re-engage individuals lost to care and bring them back into care (e.g., phone calls and letters after missed appointments) and linkages to care for individuals testing positive through Part A primary care sites, Part C early intervention clinics, and at HIV counseling and testing sites. **Based in part on the Unmet Need results, Primary Care retained its #1 ranking and funding was allocated to address projected numbers accessing primary care. Additionally, HIP was prioritized at #7 and funded as a new core service.**

■ ***METHODOLOGY***

1) Planning and Resource Allocation

1) A. Letter of Assurance – Items *(1)* through *(5)* are addressed in Attachment 2.

1) B. Description of Priority Setting and Allocation Process

The Priorities Committee, which is **completely comprised of unaligned members of whom 55% are consumers**, developed recommendations for priority category rankings and allocations for FY14 during meetings held on May 29, June 11, June 24, July 15, and July 30, 2013.The recommendations of the Committee were reviewed by the Executive Committee and approved by the full Planning Council on August 15. All Council meetings, including those of the Priorities Committee, are open and allow for input from the general public. The 2012-13 voting membership, which approved priority rankings and allocations for FY14 funding, was **comprised of individuals from historically underserved populations with 74% People of Color, 53% female, 2% transgender, 40% PLWH, and 38% unaligned consumers**.

(1) **The needs of persons not in care were considered.** During the priority setting process, the Priorities Committee used data sources and limited anecdotal information to determine the needs of PLWH who know their status but are not in care. To ensure that Part A funded services facilitate access to and retention in primary care, the Committee recommended continuation funding (through the Planning Council budget) for the AAOI, a day-long session focusing on persons who are living with HIV disease, are aware of their status, but are not in care or have been lost to care. This initiative seeks to facilitate access to care, and also serves as a mechanism for evaluating barriers which have kept these individuals from care. The FY13 AAOI will expand its focus to include consumer education on insurance eligibility and enrollment. The Committee recommended funding for a Patient Navigation pilot program to reduce barriers to care and to improve treatment adherence.

(2) **The needs of persons unaware of their HIV status were considered.** Based on CDC calculations, there are **an additional 8,365 who are unaware of their HIV status**. Needs assessment and unmet need data for the general PLWHA population were provided to the Priorities Committee. While these data were derived using information based on individuals who are aware of their status but not in care, there is the presumption that these similar needs will be reflected among persons who are unaware of their status.

(3) **The needs of historically underserved populations were considered.** As stated above, the Council provides opportunities for historically underserved populations to participate in the priority setting process. An example of this is the active Consumer Caucus comprised of PLWH who utilize Part A funded services and informs the Council of the needs of HIV-infected communities. Representatives from the Caucus were instrumental in assisting the EMA's AETC with assisting consumers complete *The Consumer Survey* used to compile important needs data. Data derived from the consumer surveys, along with presentations to the Priorities Committee during the priority setting process, guided the Committee in its decisions to maintain certain services so that gaps in services would not be created. Also, the Council provides opportunities for populations such as the Aging, Transgender, Women of Childbearing Age, and Young African American MSM to express concerns through participation on Planning Council Committees, Consumer Caucus, and AAOI which in turn becomes information that is used by the Priorities Committee during deliberations.

(4) **PLWHA are involved in all aspects of the priority setting and allocation processes and their priorities are considered in the processes.** The Priorities Committee held five priority-setting sessions which were open to the public and questions were addressed. While only Committee members can engage in intense deliberation and ultimately vote on the final recommendations, there are numerous opportunities for PLWHA to participate in the discussions. The Committee also considered information from *The Consumer Survey* which included gaps and barriers identified by 715 survey respondents. **Further evidence of PLWHA**

participation in this process is of the 11 Priorities Committee members, six (6) or 55 % of the members are PLWHA.

(5) **Data were used to increase access to core medical services and to reduce disparities in access to the continuum of HIV/AIDS care in the EMA.** During the priority-setting process, the following data were used: "HIV/AIDS Epidemic and Unmet Needs: Atlanta EMA and Georgia"; 2012 Atlanta EMA Demographic and Service Utilization Analysis; *The Consumer Survey*; 2012 Ryan White Statewide Client Satisfaction Survey; 2012 Atlanta EMA Unmet Need Analysis; 2012 Atlanta EMA Ryan White Unit Cost Analysis for Core and Support Services – June 12, 2013; Georgia ADAP/HICP Update 2013; Georgia Ryan White Part B Update – June 21, 2013; Georgia's HIV Health Information Exchange (HIE); Georgia HIV Prevention Team; Fulton/DeKalb County High Impact HIV Prevention Program (HIPP); EMA Service Standards, current EMA Quality of Service Indicators and results of chart reviews; information on other available services in the community, including services provided by other CARE Act Parts, CDC, HOPWA, and SAMHSA; and presentations from experts/providers of Primary Care, Medical Case Management, Mental Health/Substance Abuse services, Oral Health services, Food and Nutrition services, Assessment Committee, Public Policy Committee, AAOI, Part B ADAP staff, and SEATEC.

Additionally, the proposed Ryan White Part A services are consistent with the Georgia Statewide Coordinated Statement of Need (SCSN). Several key SCSN objectives include 1) Ensuring continuity and availability of HIV primary care consistent with Public Health Services guidelines; 2) Providing essential comprehensive oral health care; 3) Improving access to mental health and substance abuse services; 4) Ensuring access to care for newly identified HIV positive individuals; and 5) Addressing client transportation barriers. The FY14 priority rankings align with these objectives.

Analysis of CAREWare data for CY12, indicated that a total of 13,007 clients received services representing a 4% increase over CY11 (12,551) and a 6% increase over 2010 (12,287). Part A, as the payer of last resort, augments services provided through other funding sources to support the continuum of care. Atlanta's Part A funding overwhelmingly serves Communities of Color (84% of all clients served in CY12 were People of Color with the majority [76%] being African American) and other disenfranchised communities. **Sixty-three percent** (63%) of PLWHA live below the FPL and a total of 90% live below 300% of the FPL. The priorities and allocation amounts established for FY14 will increase capacity within the continuum and allow for increased access to core services and reduce disparities in the EMA's continuum of care.

The priority rankings and recommended allocations are listed below:

Primary Care: In CY12, 11,134 (85%) clients had a primary care visit, an increase from 10,667 (in CY11). Data on unmet need, epidemiology, service utilization, capacity, unit of service costs, the availability of other funding sources, anticipated increase in new clients and the increased cost of treatment for patients, including long-term survivors, clearly indicate the need for primary care funding. This category includes medications not provided through the ADAP formulary. Also, the EMA embraces the data that show "treatment is prevention" and is effective in decreasing transmission. Compelling data were provided to substantiate the need for funding for specialty care and labs. Care provider data documented need in four areas:

- **Trends in Patient Demographics** - Patients are presenting sicker, are younger, have advanced STI's, suffer from complications from aging, and are increasingly Young African American MSM. More and more clients are entering clinics with advanced stages of the disease with comorbidities including acute renal disease, HBV, hypertension, mental

health/substance abuse issues, syphilis, TB/LTBI and thrush. These clients are remaining in the system of care for a longer period of time for treatment.

- **Labs/Medications** - Along with an increase in patients, there has been a 5% to 12% increase in the costs of labs and medications. This affects both the number of new clients that can be seen and extends the time in which a patient can get an initial appointment. Care providers noted that the wait time for a first appointment with a clinician ranged from 4 to 8 weeks.
- **Staffing** - There is a need for more physicians, mid-level providers, and specialists to reduce waiting lists or remove caps on enrollment.
- **Increased Visits** - Additional time required to treat patients for chronic diseases, patients presenting with an AIDS diagnosis, and increased numbers of walk-ins. In addition, consumers ranked primary medical care (ranked #1) and medications other than ARVs (ranked #3) as the most utilized medical services needed by eligible PLWH in *The Consumer Survey*. **Outcome:** This priority category retained the #1 ranking. The amount allocated to this category decreased as a result of the Committee's decision to add a new category and reduce funding in categories where insurance coverage is expected to reduce the impact on Ryan White funding. Primary care is one of the categories where clients may get services through insurance. The total allocation of $9,084,730 will provide services to an estimated 7,170 individuals, which includes $1,765,128 and serve an estimated 1,393women, infants, children and youth, and $2,024,218 in MAI funds to provide services to an estimated 1,598 African American and Hispanic clients.

Oral Health: Utilization data show that 3,143 clients received an oral health service in CY12 (3,127 in CY11).

The Public Health Report's 2012 Supplement No. 2 stated that, "for many low-income, under-, or uninsured individuals living with HIV, the Ryan White HIV/AIDS Program is their only source of coverage for oral health care". *The Consumer Survey* showed that the top three gaps in core services are directly related to the need for Oral Health services. **Outcome:** Priority ranking was set at #2. The allocation in this category was held harmless at the FY13 level of $1,778,454 to serve an estimated 2,984 clients.

AIDS Pharmaceutical Assistance: This category includes the same medications that are listed on the State ADAP formulary. Of the current 5,377 individuals on the Georgia ADAP, 67% (3,602) of the clients enrolled live in the EMA. Information from *The Consumer Survey*, which identified APA as #6 in gaps of services, was considered. **Outcome:** The priority ranking was set at #3. The amount allocated to this category decreased as a result of the Committee's decision to add a new category and reduce funding in categories where insurance coverage is expected to reduce the impact on Ryan White funding. The EMA did not directly support the State ADAP in its FY14 allocation; however, $1,062,654 is allocated to the local AIDS Pharmaceutical Assistance Program to serve a minimum of 1,256 clients.

Medical Case Management: Utilization data showed that 2,824 of all clients in CY12 received medical case management. This service was the 2nd most used service among clients. Those clients with a case manager reported use of primary care more frequently than those without a case manager. Currently, 27% of medical case managed clients are between 101% and 300% FPL and are potentially eligible for insurance through the Health Insurance Marketplace. The total EMA clients potentially eligible for insurance through the Health Insurance Marketplace is about 4,548 individuals. These clients will potentially need assistance with enrollment into the federally facilitated Health Insurance Marketplace and case managers will play a critical role in providing assistance in navigating the new health system. Medical case

management also includes the provision of treatment adherence. **Outcome:** This category maintained its ranking at #4 with a slight increase in funding to hire additional case managers. Funding in the amount of $1,676,217 has been allocated to serve an estimated 3,400 clients.

Mental Health and Substance Abuse: In CY12, 23% of all clients received mental health services [n=3,056] vs. 21% [n=2,843] in CY11 and 11% of all clients received substance abuse services [n=1,446] in CY12 vs. 13% of all clients [n=1,780] in CY11. *The Consumer Survey* indicates that 59% of all clients reported having received mental health services after their HIV diagnosis. Anxiety and depression were the most common mental health diagnoses. Similarly, 31% reported having received substance abuse services after their HIV diagnosis. **Outcome:** Mental Health ranked at #5 and Substance Abuse Services at #6, respectively. The amount allocated to these categories decreased as a result of the Committee's decision to add a new category and reduce funding in categories where insurance coverage is expected to reduce the impact on Ryan White funding. This does not, however, diminish the importance of mental health and substance abuse treatment in facilitating access to and retention in primary care. The Mental Health allocation of $1,255,308 to serve an estimated 2,471 clients, and the allocation for Substance Abuse in the amount of $1,076,040 will serve an estimated 1,410 clients.

Health Insurance Program: During deliberations, the Priorities Committee realized that many clients who will become eligible for health insurance under the Affordable Care Act may need assistance paying insurance premiums. The Committee received several scenarios with estimated costs to support the establishment of the Health Insurance Program to assist clients with premiums, co-pays, and deductibles. **Outcome:** This new category was ranked #7 and the Committee allocated $2,200,000 for premiums and cost-sharing assistance.

(6) **Changes and trends in HIV/AIDS epidemiology data were used in the priority setting and allocation process**. In the EMA, epidemiology data indicate that the epidemic continues to disproportionately impact African Americans, Males, and MSM. When looking at all PLWHA, there has been a shift in overall age distribution. In 2012 the total number of PLWHA increased by only 4% compared to 2009 while the numbers aged between 50 and 59 years and those over 60 years increased 10% and 14% respectively. In addition, there has been an 18% increase since 2009 in PLWHA aged between 20 and 29 years. An infectious disease clinician reported to the Priorities Committee that these clients present with late stage HIV complications and very low T-cell counts. These data were used as the basis for selecting service category rankings and allocations.

Given the relative constant nature of the epidemiology in the EMA, it was determined that wholesale revisions to the current continuum of care were not warranted**.** Utilization patterns mirror the epidemic in the EMA and services correspond to the needs identified in all recent assessments.

(7) **Cost data were used by the Council in making funding allocation decisions.** SEATEC developed the 2012 Unit Cost Analysis to estimate the average cost per service visit in calendar year 2012 for each priority category. The Unit Cost Analysis provides the basis for making comparisons across services and evaluating cost effectiveness as well as a benchmark for performance measurement. The Grantee also provided FY12 expenditure data for each priority category. Using cost data, the Priorities Committee projected the estimated number of clients that could be served within each of the priority categories.

(8) **Unmet need data were used by the Council in making priority and allocation decisions.** Unmet need data indicate that there are 7,727 PLWA and 6,964 PLWH (non-AIDS) who are aware of their status but are not in care in the public or private health care system

(Attachment 6) for a total of 14,691 individuals with HIV/AIDS who are in need of primary care in either the public or private health system. These data were used by the Planning Council to maintain the allocation for the Oral Health category, and to establish a new Health Insurance Premium (HIP) priority category. The Priorities Committee recognized the importance of balancing the need for additional primary care services against the need for funding other core services which are vital to the EMA's continuum of care.

(9) **The Planning Council considered and addressed in their prioritization and allocation process any funding increases or decreases in the Part A award.** The Planning Council established an allocation in each priority category as initial funding recommendations until notification of the final FY14 award. After receipt of the award, the Priorities Committee will reconvene to develop final allocations. This will avoid any interruption in services and allow the Committee to review the status of the program at that time, address any new challenges and maximize Part A funding.

(10) **MAI funding was considered during the planning process to enhance access to services for disproportionately impacted minority populations.** As in FY13, the Priorities Committee and the Council directed that all FY14 MAI funds be allocated to the Primary Care category to provide comprehensive treatment and care to minority populations. The use of MAI funding for this purpose is consistent with the EMA's prioritization of Primary Care as the number one priority service category. MAI funding will provide quality primary care services that are comprehensive, geographically accessible, remove barriers to care, and improve health outcomes in African American and Hispanic communities disproportionately impacted by the HIV epidemic.

(11) **Data related to EIIHA were used in the priority and allocations decision making process.** Using surveillance data and information regarding the special needs of emerging populations, the Priorities Committee considered these populations identified in EIIHA:

African Americans - Young MSM (15-30) and MSM (30-45) – AIDS incidence and prevalence has been the highest among men who have sex with men. Among newly reported cases of AIDS in the EMA during 2012, MSM accounted for 46% of all cases (42% in 2009). In light of the above data and other challenges documented for this population (racism, homophobia, poverty, and lack of access to health care services), funding was allocated for the Primary Care and HIP categories and to other core and support services.

African American Heterosexuals – Among newly reported cases of AIDS in the EMA during 2012, heterosexuals accounted for 6% of all cases (4% in 2009). Among African American women, having unprotected sex with a man is the leading cause of HIV infection. Most adult and adolescent women with AIDS for whom high risk activities were documented, listed heterosexual activity as their risk factor (65% in the EMA). Funding was allocated the Primary Care and HIP categories along with funding to other core and support services categories including childcare and medical transportation to facilitate treatment and care for this population.

(12) **Data from other federally funded HIV/AIDS programs were used in developing priorities**. The Priorities Committee heard presentations and assessments of the availability of other federal funds for: (1) counseling, testing and linkage services, (2) current and anticipated funding for ADAP and HICP, and (3) mental health and substance abuse funding. Based on their assessment, the Planning Council **did not** rank or fund Early Intervention Services due to the availability of CDC funds for counseling, testing, and linkage services, funded the local AIDS Pharmaceutical Program and **not** the State ADAP and HICP due to the availability of other

funding. The funding levels for mental health and substance abuse services were decreased given the availability of SAMHSA funds and the potential impact of the ACA.

(13) **Anticipated changes due to the Affordable Care Act were considered in developing priorities.** As of this writing, Georgia has declined to implement Medicaid expansion. Based on CAREWare data, it is estimated that 8,157 clients in the EMA have incomes below 100% FPL and will need access to care and treatment. Also, 2,165 persons with incomes between 100% and 150% of FPL would be eligible for insurance through the Health Insurance Marketplace insurance without Medicaid expansion and 2,383 persons with incomes between 150% and 300% will be eligible for insurance coverage in the Marketplace. The Priorities Committee was deliberate in allocating funds to Primary Care, Oral Health, and other core and support services to maintain a system of comprehensive care for those whose income is 100% of the FPL or less.

During deliberations, the Priorities Committee realized that many clients who will become eligible for health insurance under the Affordable Care Act may need assistance paying insurance premiums. The Grantee surveyed other EMAs to determine how much other cities allocate for this service and the process used to make payments. The Committee was provided with several scenarios with estimated costs and, based on the information received, established the Health Insurance Program as a new category to assist clients with premiums, co-pays, and deductibles.

Currently, 27% of medical case managed clients are between 101% and 300% FPL and may be eligible for insurance through the Health Insurance Marketplace and the total number of EMA clients potentially eligible for insurance through the Health Insurance Marketplace is about 4,548 individuals. These clients will need assistance with enrollment into the federally facilitated Health Insurance Marketplace and case managers will play a critical role in providing assistance in navigating the new health system.

The Grantee received technical assistance from HRSA to assist in the development of a Patient Navigation Pilot Program model that will navigate clients through the process of how to access community and clinical resources to address individual barriers that may prevent them from accessing treatment services. The Committee allocated $64,000 for the implementation of the pilot program.

1) C. Description of Community Input Process.

Not applicable as the Atlanta EMA is governed by a Planning Council.

1) D. Funding for Core Medical Services. See Attachment 8.

1*)* E. <u>Early Identification of Individuals with HIV/AIDS (EIIHA)</u>

(1) **EIIHA Plan Background Summary**

(a) **Description of the overall EIIHA Plan since initial implementation includes:**

- **Summary of how the EIIHA Plan was developed and implemented:**

In 2010, the EMA established the Early Identification Workgroup which brought together leadership of Parts A, B, C, and D; SEATEC; DPH HIV Surveillance Program; DPH HIV Prevention Program including the Georgia Community Planning Group; HIV Testing/Partner Services Program; City of Atlanta HOPWA; and CDC and State funded counseling and testing and prevention providers. Presentations were made by participants on epidemiological data, unmet need data, identified high risk populations targeted in the prevention

programs, mapping of locations of core and supportive services available, and challenges encountered.

The main EIIHA Plan objectives are included in the 2012-2015 Atlanta EMA Comprehensive HIV Services Plan (Comprehensive Plan) and will integrate care and treatment services with HIV counseling, testing, and linkage (CTL) and prevention programs. Included are: **Goal 2:** To reduce disparities in access to health services and related support services among disproportionately affected populations and historically underserved communities; **Goal 3:** To identify individuals aware of their status, but who are not in care, and link them to core medical and support services; **Goal 4:** To coordinate and integrate care and treatment services with HIV counseling and testing and prevention programs.

Collaborative efforts required to implement the EIIHA plan included identifying all prevention and treatment partners, promoting strong collaboration among partners, targeting high risk populations, developing activities to address barriers for reaching the target populations and ensuring that proper documentation is collected.

State, county and local prevention programs are responsible for:

- Providing linkage to care services at testing sites, including emergency rooms that serve as the health provider for many individuals without a medical home.
- Coordinating with disease investigators in funded health clinics to ensure linkage and follow-up for individuals contacted through partner notification services.
- Ensuring that funded clinics have protocols in place for providing HIV testing to individuals presenting in STD clinics.
- Ensuring the sharing of client information between STD and HIV clinics.

Part A responsibilities included:

- Developing a baseline of the community viral load of targeted areas through CAREWare data collected from the 10 Part A funded primary care sites.
- Monitoring data to evaluate impact of programs for individuals tested, counseling, linked to care, and started on therapies to reduce viral loads and increase T-cell counts.
- Providing CD4 and viral load data from CAREWare to assist prevention efforts in identifying the geographic areas with the highest community viral load.
- Ensuring that primary care providers discuss secondary prevention efforts as part of each primary care visit including partner reduction, mutual monogamy, and correct and consistent use of condoms. Target groups in the current EIIHA Plan are: African American (AA)–MSM 15-30; AA–MSM 30-45; and AA Heterosexuals. Target groups were chosen as a result of epidemiology data which indicated an increase in the living cases of HIV and newly reported cases of AIDS, unmet need data, and utilization data in CAREWare.

- **EIIHA data have been collected and are in the process of being analyzed.**

Counseling, testing, and linkage data (Evaluation Web) are provided to the EMA for review and utilization in planning for services. Through the centralized CAREWare database, the EMA is assisting agencies by verifying enrollment of the newly diagnosed and those returned and retained in care. The DPH Epidemiology Section created the Continuum of HIV Care (Care Treatment Cascade) for the EMA and provided a presentation to the Planning Council. The EMA's Continuum of HIV Care indicates that 46% of adolescents and adults diagnosed with

HIV in 2011 have viral suppression. This baseline information will guide the EMA's efforts to increase linkage and engagement in care and improve health outcomes.

- **Major successful outcomes of the EIIHA Plan include:**
  - A unified system in the EMA to promote the identification, linkage to care, and retention in care
  - Placement of linkage coordinators in 4 of the EMA's primary care sites including Fulton County Department of Health and Wellness, DeKalb County Board of Health, Cobb County Board of Health, and Clayton County Board of Health to augment counseling and testing activities
  - Creation of Metro Atlanta Testing and Linkage Consortium (MATLC)
  - Increased collaboration among partners to allow complete participation in all aspects of processes including planning, monitoring and evaluation of the Plan
  - Development of AAMSM anti-stigma campaign
  - Sharing of DPH surveillance data to develop an epidemiological profile of the EMA
  - Sharing of EMA CAREWare data to complete risk factor information in DPH surveillance eHARS database
  - Development of an EMA Continuum of HIV Care by DPH to provide baseline data to assist in improving health outcomes
  - Sharing of EMA CAREWare data to evaluate success of testing and linkage programs
- **Major challenges include:**
  - Lack of capacity at some primary care sites to accept new patients or clinics have a 4-6 week wait for a new appointment
  - Absence of a shared strategic plan to implement activities
  - Burdensome hiring process at all governmental agencies to achieve goals
  - Changes in staffing requiring additional time and focus to keep all participants up to date
  - Adequate staffing at CBOs to verify client compliance with medical appointments and/or partner services referrals
  - Georgia statute prohibiting data sharing with private physicians which prevents out-of-care notifications in real time
  - Multiple independent data systems inhibiting information sharing
  - Unlike other chronic diseases, an HIV/AIDS diagnosis still involves stigma
- **The EIIHA Plan has contributed to achieving the goals of the NHAS by** reducing new infections through provision of treatment and retention in care; increasing access to care through strategic placement of linkage coordinators and optimizing health outcomes through enrollment and retention in care, and reducing HIV-related health disparities through location of CTL sites and treatment sites along with provision of supportive services to promote access to and retention in care.

(b) **The 3 target populations selected are: African American (AA)–MSM 15-30; AA–MSM 30-45; and AA Heterosexuals**. Data are included below on each of the populations for the period **January 1, 2013 – June 30, 2013** from Evaluation Web.

AA-MSM 15-30	**Newly Diagnosed**	**Previously Diagnosed**
Number of test events	1,615	1,615
Number of positive test events	159	53
Number of positive test events with client linked to/or re-engaged into HIV medical care	74	13

Number of confirmed positive test events	139	50
Number of confirmed positive test events with client interviewed for Partner Services	61	35
Number of confirmed positive test events with client referred to prevention services	122	46
Number of confirmed positive test events who received CD4 cell count and viral load testing	Data Not Available	Data Not Available

AA–MSM 30-45	**Newly Diagnosed**	**Previously Diagnosed**
Number of test events	617	617
Number of positive test events	48	46
Number of positive test events with client linked to/or re-engaged into HIV medical care	21	12
Number of confirmed positive test events	46	45
Number of confirmed positive test events with client interviewed for Partner Services	22	42
Number of confirmed positive test events with client referred to prevention services	33	43
Number of confirmed positive test events who received CD4 cell count and viral load testing	Data Not Available	Data Not Available

AA Heterosexuals	**Newly Diagnosed**	**Previously Diagnosed**
Number of test events	17,811	17,811
Number of positive test events	70	57
Number of positive test events with client linked to/or re-engaged into HIV medical care	20	15
Number of confirmed positive test events	54	51
Number of confirmed positive test events with client interviewed for Partner Services	31	44
Number of confirmed positive test events with client referred to prevention services	43	46
Number of confirmed positive test events who received CD4 cell count and viral load testing	Data Not Available	Data Not Available

(2) **EIIHA PLAN**

(a) **The planned activities of the EMA EIIHA Plan for FY14 including the following.**

- **An updated estimate of individuals who are HIV positive** and who do not know their HIV status is **8,365**. The estimate was calculated based on the number of living cases of AIDS and HIV 31,469 multiplied by .21/.79. This is based on the most recent formula provided by the CDC to estimate the number of unaware.
- **The target populations are: African American (AA)–MSM 15-30; AA–MSM 30-45; and AA Heterosexuals**.
- **The primary activities that will be undertaken include:**
  - On-going testing in clinical and non-clinical sites

- Modification of CAREWare database to include counseling, testing and linkage data
- Updates to partners on availability of primary care and other core and supportive services
- Sharing of information on the new Health Insurance Program and the process to make application
- Implementation of the patient navigator program to assist linkage coordinators with enrollment and retention in care
- Evaluation of unmet need data by zip code to determine locations with high community viral load in order to focus testing and outreach efforts

- **Major collaborations with other programs and agencies include:**
  - Participation of Part A Planning Council member on DPH Community Planning Group and Fulton County HIP Planning Group
  - Grantee participation in routine conference calls regarding CAPUS and HIE updates
  - Assisting CTL sites in verifying enrollment in primary care and receiving tests for CD4 and viral load
  - Bi-weekly meetings with DPH and Part B leadership to plan for transition of clients into the Health Insurance Marketplace and its impact on current system of care within the EMA including ADAP and HICP
- **Planned outcomes of the overall EIIHA strategy include:**
  - Seamless entry from CTL sites into primary care with services in place to retain clients in care
  - A coordinated system for CTL, prevention and treatment programs in the EMA that reduces duplication of services and maximize all funding sources
  - Reduction in health disparities and access to care

(b) **The EIIHA Plan contributes** to the goals of the NHAS through activities that identify, inform, refer and link HIV positive persons to: 1) reduce HIV infection; 2) increase access to care; 3) improve health outcomes; and 4) reduce HIV-related health disparities.

(c) **The Unmet Need estimate** informs and relates to the EIIHA planned activities by identifying populations aware but not in care by race, gender, age, and risk factor along with geographic location by zip code to focus counseling and testing and outreach efforts.

(d) While there are **no apparent legal barriers to routine testing**, anecdotal information suggests that the partner notification requirement of Georgia law may be a deterrent to testing. In addition, a current law categorizes hypodermic needles as illegal drug paraphernalia, which is the barrier to implementing programs and activities that address prevention of persons who inject drugs. Information provided by the State's Prevention Program indicates that many physicians are not aware of the CDC's recommendation for routine testing for HIV. Additional efforts are required to educate providers on the CDC recommendations. In addition, there remains a very cautious atmosphere in the community when there is any consideration of revising the current AIDS statute because of stigma and fear of the final outcome.

(e) **The three target populations chosen are: African American (AA)–MSM 15-30; AA–MSM 30-45; and AA Heterosexuals**.

- **The AA-MSM 15-30** population was chosen based on prevalence of HIV and the increase in the number of AIDS incidence cases reported over the last three years.
- **The AA-MSM 30-45** was identified based on analysis of prevalence data and the unmet need data indicating 42% AA-MSM aware of their status but not in care.
- **The AA Heterosexual** population was chosen based on analysis of prevalence data indicating that African American women account for 78% of all PLWHA in the EMA.

- **Specific challenges include barriers that** obstruct awareness of HIV status including access to general HIV information and the benefits of early treatment, lack of targeted prevention messages, poverty, stigma, access to regular health care, racism and reluctance to talk about sex and drug use. Additional challenges are identified in trying to inform individuals of their status since they may have relocated and counselors are unable to contact along with the inadequate number of public health staff to assist all counseling and testing sites in locating and informing individuals of their status. **Opportunities to work with the populations include** outreach services conducted by community based organizations funded by the DPH Prevention Program and the Fulton County Department of Health and Wellness for targeted testing in clinical and non-clinical settings, outreach activities to high risk populations and those not returning for test results through designated health department staff, offering counseling and testing of high risk populations at the EMA's AAOI, and the statewide social marketing campaign targeted at high risk populations to encourage counseling and testing.
- **Specific activities to be utilized with the target populations include** strategically placed testing sites, targeted prevention messages including treatment as prevention, geographically located primary care sites and the availability of medical transportation and other support services to support access and retention in care.
- **Specific objectives for each component of EIIHA for the target populations include:**
  - **Increase the number of newly identified** HIV positives through targeted test events by 10% from January 1, 2013 through December 31, 2013.
  - **Increase the number of HIV positives informed of their status** through outreach and partner services efforts by 20% from January 1, 2013 through December 31, 2013.
  - **Increase the number of HIV positives referred for** medical care by 20% from January 1, 2013 through December 31, 2013.
  - **Increase the number of HIV positives linked to** medical care by 20% from January 1, 2013 through December 31, 2013.
- **The responsible parties include** the DPH Prevention Program, the Fulton County Department of Health and Wellness, and CDC funded sites. Each program would be responsible for monitoring of counseling and testing data by site to ensure accurate data are captured on reporting forms, completing referral forms and documenting linkage to medical care by each program funded linkage coordinators. The Part A program will assist programs by modifying CAREWare to include variables necessary to document all steps from testing through linkage.
- **Planned outcomes to be achieved by implementing EIIHA Plan activities are to:**
  - **Increase the number of individuals** who are aware of their HIV status
  - **Increase the number of HIV positive individuals** who are in medical care through strategically placed linkage coordinators
  - **Increase primary care retention rates through assistance of patient navigators**
  - **Reduce new infections** through the provision of ART
  - **Reduce HIV health-related disparities by** providing additional core medical and supportive services including medical transportation and childcare
  - **Increase collaboration and coordination** as a result of leadership in key programs promoting and supporting opportunities for partnerships

(f) **The EIIHA Plan will be presented to the** Early Identification Workgroup, the Quality Management Committee, and shared with all community partners for comment prior to completion of the final document. A work plan will be developed and updated quarterly for distribution and sharing with the Planning Council and other members of the community.

- ***WORK PLAN***

1. Access to HIV/AIDS Care and the FY 2014 Implementation Plan

1) A. Continuum of Care for FY14

Ryan White Part A funding supports a comprehensive range of primary care and essential support services for eligible persons residing in the 20-County EMA. Part A-funded agencies provide HIV care programs designed to address health and emotional support-related needs of persons living with HIV/AIDS throughout the EMA. Coordination with other programs and services at the local level helps to assure that needs of Part A clients are optimally addressed while requirements of various funding streams are also met. Integration of other services with Part A linkage and delivery mechanisms facilitate access to and promote health care retention for newly diagnosed, underserved, hard-to-reach individuals and/or disproportionately impacted communities of color, and those who know their HIV status but are not presently in HIV primary medical care. The Comprehensive Plan outlines a strategic approach to HIV program development and service provision that is based upon data obtained from epidemiological reports, the most recent Consumer Needs Survey and Unmet Need Estimate report/framework.

Atlanta EMA Implementation Plan objectives are based upon the goals and objectives in the Comprehensive Plan, which outline strategies among EMA agencies, the Grantee, and the Planning Council to achieve health improvement outcomes among people living with HIV. Desired health outcomes associated with FY14 Implementation Plan objectives and Comprehensive Plan goals align with Health Resources and Services Administration (HRSA) Strategic Plan and NHAS goals and Healthy People 2020 objectives to improve access to quality health care services and decrease health disparities/improve health equity among affected subpopulations and historically underserved communities.

The Atlanta EMA is collaborating with the Fulton County Department of Health and Wellness High Impact HIV Prevention Program (HIPP) funded through CDC. The purpose of the HIPP is to maximize the impact of prevention efforts for all individuals at risk for HIV infection, including gay and bisexual men, communities of color, injection drug users, transgender, women, men and youth.

The intent of the Affordable Care Act (ACA) is to "expand health insurance coverage while also reforming the health care delivery system to improve quality and value." Provisions of the Act include eliminating health disparities, increasing access to health care, expanding and improving the health care workforce and encouraging consumer wellness. Beginning in 2014, many current clients will have health insurance coverage. As coverage and receipt of services among EMA consumers may change after implementation of the Affordable Care Act, the Grantee, providers, Planning Council Committees and consumers have engaged in efforts to prepare for health care reform by offering:

Client Education: The Planning Council developed consumer education tools that will assist clients through the process of determining how the ACA may impact their healthcare. These education tools will help guide clients to the appropriate resources necessary for enrollment into the Health Insurance Marketplace.

Community Forums: The Grantee will host a series of ACA Community Forums to provide information, answer questions and assist clients understand the new health care environment. Also, several providers in the EMA have held their own ACA events.

Providers Technical Assistance: Service providers within the EMA have offered peer-to-peer technical assistance to ensure that agencies are enrolled as essential service providers with the different companies providing insurance in the new Health Insurance Marketplace.

Health Insurance Navigators: As previously noted, the Planning Council will host the FY13 AAOI in February 2014. The initiative is to help newly diagnosed people access care. In response to the implementation of the ACA, the AAOI will offer Health Insurance Navigators who will be available to answer questions and assist eligible clients navigate and enroll into the Health Insurance Marketplace.

The Grantee held a Ryan White Symposium on Health Care Reform in August 2013 to involve providers, consumers, other community stakeholders and administrators in a discussion and initial planning exercises. The purpose of the Symposium was to promote understanding of how the Affordable Care Act may likely impact Ryan White consumers and service providers in the Atlanta EMA. Symposium participants were encouraged to identify potential resources and opportunities, and were tasked with generating a plan for initial steps to move forward. Consumer and provider education and billing support information were identified as areas appearing to warrant particular attention. Clayton County, one of the health districts primarily serving a southern suburban area of the EMA, has planned and hosted various meetings for providers and consumers. Another example of efforts to plan for ACA impact is inclusion of a goal to evaluate and respond to the impact of the ACA on systems and services in the Comprehensive Plan. The Grantee and contracted service providers have participated in various ACA- related webinars and regularly consults sources such as Policy Clarification Notification Updates towards maintaining understanding of the most current available information.

ACA presents both challenges and opportunities for Ryan White Part A- funded programs. New reimbursement systems will need to be in place, and patient enrollment into the new health care coverage options will likely require modifications to current processes. Mechanisms within the EMA that enable newly infected, underserved, hard-to-reach individuals, emerging populations and/or disproportionately impacted communities of color to access and remain in primary care may be enhanced. The Priorities Committee added an additional service category, Health Insurance Program, to assist clients with cost of health insurance premiums, deductibles, and co-pays. The Case Management priority category funding was increased from the previous year to assist clients navigate the Health Insurance Marketplace.

Primary Medical Care: The primary care system includes components designed to increase access to care for all eligible clients, including services targeted to women, infants, children, youth, minorities, and underserved populations. Physician and other medical personnel practices are based upon standards of care developed and directed by the Department of Health and Human Services (DHHS) and the Planning Council. Primary care and other core services available in the EMA are complemented by various support services such as medical transportation and childcare to assist clients with accessing and maintaining HIV treatment. All awarded MAI funds are allocated to the Primary Care priority category in an effort to facilitate access to medical treatment and retention in care among People of Color.

Clients often enter the HIV care continuum through the public health system, subsequent to receipt of a positive HIV test result. Counseling and testing activities are co-located with medical care services in the health departments and other nonprofit primary care facilities. Co-location of services allows counseling and testing staff ability to accompany clients to the on-site clinic upon notification of a positive HIV status, so that they may immediately initiate enrollment into care. Medical case managers, peer counselors, and other social service

professionals provide information about available services and refer clients to primary care, specialized treatment and support services as indicated through a standardized screening.

During a typical intake, a specialist or other designated staff enrolls the client and conducts an initial screening for medical case management, mental health, substance abuse, legal needs, and performs a TB skin test. The first primary care appointment to include a comprehensive physical examination and consultation regarding treatment options is also scheduled. A variety of other services are also provided, including viral load and CD4 testing, resistance testing if warranted, family planning services, vaccines, and other preventive and therapeutic medical services. Registered dietitians, as a component of primary care, are available to clients who require nutritional assessment and counseling to optimize primary care outcomes. Women seeking prenatal care at the primary care sites are informed of the benefits of knowing their HIV status, and are encouraged to have a confidential HIV antibody test as a standard of care. If a woman who is pregnant or of childbearing age tests positive for HIV disease, she receives counseling and information regarding the current recommendations for antiretroviral treatment to minimize perinatal transmission of the virus, provision of such medications if she consents, and referral to an HIV obstetrics specialist.

Due to high need for HIV treatment in the Atlanta EMA, a triage model of service delivery is utilized to provide primary care services. Asymptomatic patients with CD4 $\geq$ 200 are treated in the HIV/STD programs of local health departments or community health clinics. When a patient's CD4 measures < 200 and/or the patient is symptomatic, the general protocol is to refer to Grady's Infectious Disease Program (IDP) for treatment of advanced symptoms of HIV disease. In some instances where some concern such as potential interruption to care continuity is noted, an established patient who experiences a drop in CD4 count below 200 may remain with his or her current physician. Patients with active TB are treated and monitored at local health departments for treatment of HIV/TB in an effort to reduce the rate of TB transmission. Upon completion of therapy and receipt of proof that active TB has cleared, patients are triaged back to the original primary care site.

Funds approved for the Primary Care priority category are targeted towards several service options implemented across the EMA to assure access to treatment for traditionally underserved and/or minority populations. A transition or "drop-in" clinic located at Grady IDP allows homeless and other individuals with histories of missed appointments or other demonstrated difficulties complying with treatment recommendations to receive same day services without an appointment. The Fulton County Department of Health and Wellness operates three satellite clinics. The primary care clinic at AID Atlanta has expanded service hours, furthering access to treatment and improving quality of life. AID Gwinnett operates a satellite clinic in a previously underserved rural community. Additional clinics located in Cobb, Clayton and Clarke Counties serve other suburban and rural areas of the Atlanta EMA. Client medical adherence is encouraged through the use of medical adherence nurses who help patients obtain, process, and understand basic health information and services needed to make good health decisions. Health literacy and education programs encourage clients to act in a manner that is conducive to the promotion, maintenance or restoration of health. Registered dietitians are accessible at several sites upon referral. In FY13, the continuum included 11 Part A-funded Primary Care sites. **In CY12, 11,134 clients were served in 68,283 visits.**

Local AIDS Pharmaceutical Assistance Program: The Atlanta EMA supports a stop-gap measure that provides ARV medications to clients awaiting approval of their ADAP application. Approved medications are based upon the ADAP formulary (with the exception of

Fuzeon) and are made available through the local AIDS Pharmaceutical Assistance priority category. Clients have access to 11 NRTIs, 5 NNRTIs, 10 PIs, 1 Integrase Inhibitor, 1 CCR5 Entry Inhibitor and 7 Combination drugs through the State ADAP and Part A programs. Clients also have access to 34 other medications used in the treatment and prophylaxis of opportunistic infections through these same sources. The State of Georgia does not currently have a waiting list. Medications not covered by ADAP or the local AIDS Pharmaceutical Assistance program are provided with Primary Care funding. In FY13, this service is available at 11 primary care sites. **In CY12, 2,285 Clients were served with 4,666 prescriptions.**

Substance Abuse: Programs designed to address the needs of persons who experience problematic alcohol and other drug use are available to Ryan White eligible clients throughout the EMA. Substance abuse treatment works to promote involvement and retention in primary care among HIV positive persons demonstrating problematic alcohol or other drug use. Substance abuse counseling and treatment services in the EMA are designed to address the needs of specific target populations such as MSM, transgender and homeless persons. Agencies strive to provide "treatment on demand" acknowledging principles of treatment readiness and motivation. Substance abuse screening and therapeutic activities identify associated needs and facilitate linkage with medical services, mental health services, housing, drug treatment services, legal services, and emergency assistance. Other service components include HIV/AIDS risk reduction, early intervention, issues surrounding disclosure of HIV positive status, decisions around sexual behavior, and prevention methods that promote personal responsibility. Providers maintain clients in care according to individualized treatment plans. Counselors and other workers locate individuals lost to care to re-engage clients to care and to facilitate treatment linkages. In FY13 the continuum included 7 Part-A funded service providers. **In CY12, 1,446 clients were served in 9,792 counseling sessions.**

Mental Health: The current continuum includes provisions for comprehensive mental health services (including medications) provided by psychiatrists and other certified mental health professionals to individuals, groups and families affected by HIV disease. Clients may access services directly or through referral by other providers. The client is broadly assessed for depression, risk of suicide, substance abuse and addiction. In addition to the psychological assessments, clients are educated about available services, informed of their rights and responsibilities, and are linked to primary care, medical case management, treatment education, and support services. EMA agencies employ clinicians who are trained and licensed in both mental health and substance abuse treatment fields in order to meet the changing needs of newly affected and dually diagnosed clients. Funds also support specific services for Communities of Color and underserved populations, including the availability of mental health counselors and bilingual professionals. In FY13 the continuum included 10 Part A-funded Mental Health providers. **In CY12, 3,056 clients were served in 20,827 individual and group sessions.**

Oral Health: Oral health services emphasize comprehensive, high quality client-centered oral health services for HIV-infected persons in collaboration with primary care providers. Patients receive an oral health assessment (either directly or through contractual arrangement) in conjunction with the medical assessment received at primary care sites. Comprehensive oral health services include preventive, periodontal, restorative, endodontic, surgical, and prosthetic care as well as management of oral manifestations associated with HIV disease. Medications used to prevent dental decay, treat periodontal diseases and manage oral pathology are covered within this category of care. In FY13 the continuum included 8 Part A-funded Oral Health providers. **In CY12, 3,143 clients were served in 14,425 office visits.**

Medical Case Management: The EMA operates a centralized client-centered system to ensure accountability and parity, and improve the quality of service delivery. Part A funds are utilized to support 28 case managers, 17 of which are out stationed to ensure medical case management services at primary care clinics, AIDS Service Organizations (ASOs), community-based organizations (including minority Community Based Organizations (CBOs), Veterans Administration, and local jail pre-release programs. Additionally, services include bilingual case managers located in sites with concentrations of non-English speaking communities. Having medical case managers at primary care sites serves to provide a smooth transition into the continuum of care by enabling clients to have their medical and social needs met at one location. Clients are evaluated during regularly scheduled Individualized Service Plan (ISP) assessments to determine readiness to "graduate" from medical case management to self-management. Clients not requiring medical case management at that time may be referred to peer counseling (funded under psychosocial support) and are provided with a resource packet that identifies available services. Clients may be re-evaluated as conditions change. It is important to note that treatment adherence counseling is also provided to clients by registered nurses at the primary care sites as a separate component of medical case management.

Case managers coordinate other services that may be needed such as medical transportation, childcare, emergency financial assistance, mental health and substance abuse counseling, food and nutrition services, and legal assistance in an effort to reduce barriers to care. Case manager aides also assist eligible clients with enrolling in the State ADAP, HICP, and PAP. On-call case managers are available at the funded case management agency to assist clients identify and locate care and treatment resources, including assistance with bilingual and sign language needs. These include persons who have relocated to the EMA or individuals referred by the statewide AIDS Information Line. **In CY12, 2,442 clients were served in 22,226 face-to-face encounters via the centralized case management provider.**

Health Insurance Program (HIP): A new priority category was approved for funding by the Priorities Committee for FY14. This service will provide financial assistance for eligible individuals living with HIV to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This will include premium payments and other cost-sharing payments such as co-payments and out-of-pocket deductibles. For FY14, $2,200,000 was allocated to this new category to serve an estimated 1,400 clients.

Support Services: The continuum includes essential support services that address barriers to care for the newly infected and underserved persons. In order to ensure that support services lead to improved health outcomes, the EMA has a policy requiring that clients are enrolled and participating in primary care before being eligible for supportive services such as food, emergency financial assistance, psychosocial support, legal assistance, and childcare. Translation services are available in Spanish and American Sign Language throughout the continuum in an effort to increase access to care, maintain clients in care, and reduce disparities in care. Other interpretation services through a statewide language line are available to providers. The urban core is serviced by the Metropolitan Atlanta Rapid Transit Authority (MARTA), but the more suburban and rural areas have limited or no public transit. The EMA provides transportation support in the form of bus/rail passes and reimbursement for taxi/cab services to assist clients with access to core medical and other supportive services. Food and Nutrition services consistently rank first among all support services. To address this need, the EMA provides services tailored to clients' dietary needs through food pantries, mechanical soft meals (available to clients awaiting procedures in the oral health clinic at Grady IDP), and home-

delivered meals. Home delivered meals represent the largest portion of support services provided, and in CY12, 584 clients received up to 2 meals per day. Grocery vouchers are also provided.

The integration and coordination of other available services or programs with Part A funded services contributes to the EMA's continuum of care. Part A clients receive services from other programs that enhance and augment the comprehensive range of services required by individuals and families. For example, Part A clients receive housing assistance through the HOPWA program; Women, Infants, Children, and Youth receive assistance through Part D funds; Primary Care and Counseling & Testing are provided through Part C funds; Part B provides case management in rural settings; medications are provided through the State ADAP; and insurance premium payments are provided through the state HICP. In this environment of limited funding for HIV/AIDS and the increased prevalence among emerging populations, integration and coordination of services ensures timely, uninterrupted care.

Mechanisms within the EMA enable newly infected, underserved, hard-to-reach individuals, emerging populations and/or disproportionately impacted communities of color to access and remain in primary medical care. Public health and community clinics serve as the foundation for the provision of primary care services in the EMA. Geographically located in communities where the majority of persons are minorities, indigent, and uninsured, and who represent the populations least likely to have access to care, these clinics enable disenfranchised populations to access care. Several clinics serve as "one-stop shops" that provide comprehensive services such as primary care, mental health treatment, substance abuse treatment, oral health care, medical case management, and support services in one location. This works to facilitate client access and reduce barriers to system navigation. If a needed service is not readily available at one location, linkages are made.

The EMA funds AIDS Pharmaceutical Assistance programs in primary care sites which allow timely access to therapies and prophylaxis for opportunistic infections as a stop-gap measure until enrollment in ADAP or PAP has been completed, and for long-term clients who are ineligible for ADAP due to the state requirement that a patient must be on HAART.

A primary care site located in a district with high rates of HIV and STIs provides a rotating clinic in which staff travel among three geographically dispersed health centers throughout the county one day per week to provide newly diagnosed HIV clients initial health assessments and routine care.

Peer counselors and other staff provide follow-up contact attempts if clients begin to exhibit a pattern of missed appointments and/or there are problems in locating a client. Once located, the individual is referred to a case manager or other social service provider who assists with re-entry into the primary care system. Additionally, the EMA will launch a Patient Navigation pilot program with the purpose of helping clients link to and remain in primary care and other services.

Newly and previously infected individuals who may have been infected for a longer period but have only recently been tested, access care through linkage coordinators, case managers, intake staff, and peer counselors. Support services such as medical transportation, childcare, legal assistance, psychosocial support, and translation help reduce barriers to care and promote retention.

1) B. Table: FY 2014 Implementation Plan – See Attachment 9.

The EMA's **four core medical service categories** comprising the largest amounts of Part A funding allocated to Core Services are Primary Medical Care, Health Insurance Program, Oral Health, and Medical Case Management. The **two categories** comprising the largest amounts of Part A funding allocated towards Support Services are Food and Psychosocial Support. **MAI**: 100% of the EMA's MAI funds are allocated to Primary Care. Comprehensive Plan goals correspond to each of the six Implementation Plan service category objectives.

1) C. Narrative

(1) **The EMA links its latest needs assessment (including results of the EMA's Unmet Need Framework), service priorities, the FY 2014 Implementation Plan, and the 2012 Comprehensive Plan, including how the goals and objectives relate to the strategies identified in the Comprehensive Plan.** Information obtained from the Needs Assessment/ Unmet Needs Framework along with Consumer Needs Survey data inform decisions around identification of service priorities, which are incorporated into the Comprehensive Planning activities. These data are also considered by the Priorities Committee in order to make determinations around priority categories to be funded each year. The FY14 Implementation Plan is based upon goals and objectives outlined in the Comprehensive Plan and information obtained from the work of the Planning Council committees. Coordination among the various Planning Council committees' activities assures a progressive planning process for the EMA's continuum of care. All of the information gathered during this process was instrumental in the priority-setting process for FY14 funds.

The Planning Council committees utilized *The Consumer Survey* data to guide decision-making during the priorities process for FY14. Consumer data were used by the Comprehensive Planning, Priorities, and Assessment Committees to address needs associated with service gaps reported by survey respondents. *The Consumer Survey* results were presented and explained on several occasions to various committees comprising the Planning Council.

The Comprehensive Plan contains the overarching directives that guide the Planning Council and its committees, and the Consumer Caucus in their planning process. The Comprehensive Planning Committee engaged in ongoing communication with other Planning Council committees in developing the Comprehensive Plan. Data from *The Consumer Survey* were incorporated into the Comprehensive Plan. Comprehensive Planning activities involved review of relevant data and assuring consistency across goals and objectives.

The Consumer Survey identified populations and demographics with the most gaps in services, and helped identify population demographics associated with greatest service gaps and barriers to care reported (e.g., Transgender, MSM).

The results of the HRSA/HAB Unmet Need Framework indicated the need to: include activities to identify individuals "lost to care" and return them back into care; link individuals testing positive to early intervention services; and ensure that funding is available to provide access to other core services such as substance abuse and mental health to address the anticipated increase in the number of PLWH.

Priority category objectives included in the Implementation Plan are based on documented need for specific services and gaps identified in care. Service priorities were developed, ranked, and assigned recommended allocation levels by the Priorities Committee to fund activities that address disparities in HIV care among subpopulations. FY14 Implementation Plan priority category objectives reflect the results of *The Consumer Survey*, unmet need

framework, guidance provided in the Comprehensive Plan, and recommendations of the Priorities Committee adopted by the Planning Council.

(2) **Prioritized core services that will not be funded with FY 2014 Ryan White HIV/AIDS Program funds include:**

- **Early Intervention Services (EIS):** This service is provided by 5 sites that receive Part C funding.
- **Home Health:** Data suggest that there is little need for this service.
- **Hospice:** Data suggest that there is little need for this service. Medicaid and/or third-party insurance will provide the service for eligible clients.

(3) **The activities described in the Plan will provide increased access to the HIV continuum of care for minority communities**. As previously stated, epidemiological data show that People of Color, specifically African Americans and, to a lesser extent, Hispanics, are disproportionately impacted by HIV. Other populations disproportionately impacted include women and all people in the age groups of 30 to 39 and 40 to 49. The FY14 Implementation Plan includes initiatives to ensure minority communities have access to and remain in care. Access is further enhanced through services that are offered in a culturally competent and language appropriate manner. In addition to the core and support services outlined in **Attachment 9**, the continuum includes other supportive services such as medical transportation, childcare, and emergency utility assistance in order to increase access to care and support retention.

Primary Care: The provision of accessible primary medical care through public health centers and community clinics. (Service Category 1, Objective 1).

Primary Care: The provision of primary medical care and HIV-care medications to women, infants, children, and youth (Service Category 1, Objective 2).

Primary Care – MAI: The provision of primary medical care to provide increased access to quality primary care for African Americans and Hispanics (Service Category 1, Objective 3).

(4) **The Plan addresses the needs of Emerging Populations including Young African American MSM, Women of Childbearing Age, Transgender and the Aging through the following activities.**

The FY14 Implementation Plan summarizes general service objectives corresponding with the four core and two support service priority categories to which the largest amounts of total award funding are recommended for FY14 allocation. Service categories outlined in the Implementation Plan are Primary Care, Health Insurance Program, Oral Health, Medical Case Management, Food and Psychosocial Support. Emerging populations identified in the Demonstrated Needs section are Young African American MSM, Women of Childbearing Age (15-49) years, Aging (50+ years), and Transgender persons.

Emerging populations in the Atlanta EMA were identified based upon data indicating recently evident or continued increases in prevalence/incidence, high reported service gaps, and disparate health status measures or outcomes. The needs of historically underserved populations such as transgender persons, MSM, the aging and Women of Childbearing Age will continue to be addressed by assuring access, affordability and support among PLWHA. Primary Care, Health Insurance Program, Oral Health, Case Management, Food, and Peer Support services work to reduce health disparities among PLWHA.

Primary Care: The provision of primary medical care and HIV-care medications through public health centers and community clinics located in the EMA, including services to Women, Infants, Children, and Youth. Additionally, Minority AIDS Initiative funds will be used to

increase access to quality primary care services to African Americans and Hispanics that are disproportionately impacted by HIV. Core Medical Service Category 1, Objective 1 (All populations), Objective 2 (Women of Childbearing Age) and Objective 3 (All populations).

Health Insurance Program: To provide assistance with health insurance premiums and cost-sharing payments such as co-payments and deductibles. Core Medical Service Category 2, Objective 1 (All populations).

Oral Health: The provision of preventive, restorative, and prosthetic dental care services. Core Medical Service Category 3, Objective 1 (All populations).

Medical Case Management: The provision of comprehensive, community-based medical case management services that will identify and assess the needs of PLWH and increase access to primary care and support services. Core Medical Service Category 4, Objective 1 (All populations).

Food: The provision of home-delivered meals, grocery vouchers, and access to food pantries. Support Service Category 1, Objective 1 (All populations).

Psychosocial Support: The provision of individual and group peer-led counseling to clients in need of emotional support, particularly those who are newly-diagnosed or have re-entered the continuum of care. Support Service Category 2, Objective 1 (All populations).

(5) **The Plan includes activities that encourage PLWHA to remain engaged in HIV/AIDS primary medical care and adherent to HIV treatments.** In addition to the service priority goals and objectives listed below, Part A funds are used to support an annual AAOI. This initiative focuses on persons who are living with HIV disease, are aware of their status, but are not in care.

Primary Care: Provide primary medical care (which includes medication adherence activities) through public health centers and community clinics in the EMA (Core Medical Service Category 1, Objective 1); to WICY (Objective 2); and to Communities of Color (Objective 3). Specific activities include: medication adherence staff, quality management standards, and accessible care through rotating clinics, satellite clinics, and clinics with extended hours.

Health Insurance Program: The provision of assistance for eligible individuals with HIV to maintain continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments and cost-sharing payments such as co-payments and deductibles (Core Medical Service Category 2, Objective 1, Comprehensive Plan Goals 1, 2, and 6).

Oral Health: Provide preventive, restorative, and prosthetic dental care services (Core Medical Service Category 3, Objective 1, Comprehensive Plan Goals 1 and 2). Specific activities include the treatment of oral health manifestations that inhibit medical adherence.

Medical Case Management: Develop and/or monitor Individualized Service Plans (ISPs) to identify and assess clients' needs (Core Medical Service Category 4, Objective 1, Comprehensive Plan Goals 1, 2 and 3). Specific activities include: treatment adherence, follow-up on medical appointments, linkages to appropriate services and development of plans that assist with life management and bilingual medical case management services at primary care sites for Hispanics.

Food: Improve the nutritional status of HIV positive clients, to support adherence to treatment regimens, and to reduce medication contraindications. (Support Service Category 1,

Objective 1, Comprehensive Plan Goals 1 and 2). Specific activities include: providing nutritious home-delivered meals to clients, providing grocery vouchers to needy clients, and providing client access to food pantries.

Psychosocial Support: Provide activities to increase and enhance access to and retention in primary medical care (Support Service Category 2, Objective 1, Comprehensive Plan Goals 1, 2 and 3). Specific activities include: peer-led individual and group counseling sessions/workshops to clients in need of emotional support and counseling, particularly those who are newly diagnosed or are re-entering the continuum of care.

(6) **The activities in the Plan promote parity of HIV Services throughout the EMA. The EMA has worked to achieve parity by establishing a comprehensive system of care and services with specific initiatives listed below:**

Geographic location of services: HIV services, including core medical and supportive services, are geographically located throughout the EMA. The continuum of care is setup to accommodate the needs of PLWHA whether they reside in urban, suburban, or rural areas within the EMA. In FY13, one new primary care provider was added and serves a suburban/rural population. Department of Health and Human Services (HHS) Treatment Guidelines are practiced in these facilities throughout the EMA. Funding of medical transportation support services helps to promote access to facilities not located within close proximity to a client's residence.

Quality: The EMA has adopted standards of care for Medical Case Management, Mental Health, Substance Abuse, Outreach, Nutrition, Oral Health, Primary Care, Peer Counseling, and Legal Services along with EMA Universal and System Level Standards to improve quality of care and to reduce disparities. The Quality Management (QM) Committee developed indicators, which were adopted by the Planning Council, to monitor compliance with the standards and the quality of services provided for Primary Care and Medical Case Management. Contracts with each funded agency include language requiring compliance with standards and development of an agency quality management plan which includes a set of key elements to be followed.

Comprehensiveness of services: The EMA's centralized medical case management system ensures consistency of quality and comprehensiveness of medical case management services through central training and supervision of case managers that is guided by established standards of care. This centralized system accommodates the geographic and cultural diversity of the EMA in the "out-stationing" of appropriate case managers at primary care sites and community-based organizations throughout the EMA with the highest HIV/AIDS prevalence.

Cultural appropriateness: The EMA engages in efforts to assure that all Ryan White-eligible clients, regardless of spoken language, health literacy level, ethnic background, or other culturally-related attribute, experience equity in ability to access health care and other support services. Potential communication barriers resulting from differences across spoken languages are addressed through interpretation and linguistic assistance offered throughout the EMA. Providers also generate forms, pamphlets, and other communication formats written in languages other than English. Potential differences across cognitive ability, education, and health literacy levels are addressed through specialized staff and social service professionals such as medical adherence nurses, peer counselors, and mental health and substance abuse counselors.

(7) **The planned activities assure that services delivered by subcontractors are culturally and linguistically appropriate to the populations served within the EMA.** The Grantee works closely with the Planning Council, which has adopted "Elements of Cultural Competence" to ensure subcontractors are providing services that are culturally and linguistically

specific to the population being served. The EMA adopted a directive for the provision of culturally appropriate treatment and support service programs, which is in compliance with the US Office of Minority Health's National Standards on Culturally and Linguistically Appropriate Services. These programs are provided in a language-appropriate manner (e.g. Spanish and American Sign Language) and augment other language assistance programs at provider sites. Culturally appropriate services are available in all of the service categories the EMA has identified as priority areas of need. The Grantee's RFP for Part A funding requires applicants to describe how current and proposed programs will provide services that are culturally and linguistically competent. The applicants must address "Elements of Cultural Competence" which include: Service/Project Description and Need Justification, Experience or Track Record of Involvement with the Target Population, Community Representation, Gender Identity, Language and Communication, and Staff Qualifications and Training. Ryan White Part A providers incorporate principles of cultural competency into programs and demonstrate adherence to requirements adopted by the Planning Council.

(8) **The services and their goals and objectives relate to the goals of the National HIV/AIDS Strategy (NHAS).** The NHAS outlines steps necessary to achieve three primary goals: reduce new HIV infections, increase access to care and improve health outcomes among people living with HIV, and reduce HIV-related disparities and health inequities. Comprehensive Plan goals and FY14 Implementation Plan service category objectives align with the NHAS. The Comprehensive Plan includes NHAS goals and objectives. Atlanta EMA Implementation Plan service category objectives support the NHAS goals to improve health outcomes and reduce HIV-related disparities and health inequities and are also consistent with the HP 2020 overarching goal to "Achieve health equity, eliminate disparities and improve the health of all groups."

National HIV/AIDS Strategy	Atlanta EMA FY14 Implementation Plan Objective							
	PC 1	PC 2	PC 3	HIP 1	OH 1	CM 1	Food 1	PS 1
Reducing New HIV Infections	X	X	X					X
Increasing Access to Care and Improving Health Outcomes for People Living with HIV	X	X	X	X	X	X	X	X
Reducing HIV-Related Disparities and Health Inequities	X	X	X	X	X	X	X	X

(9) **The services and their goals and objectives relate to the goals of the Healthy People 2020 initiative.** The Atlanta EMA continuum of HIV care operates in accordance with the Healthy People 2020 framework. Atlanta EMA Implementation Plan service category objectives support the HP 2020 overarching goal to "Achieve health equity, eliminate disparities and improve the health of all groups." This goal demonstrates consistency with the NHAS to reduce HIV-related disparities and health inequities. Comprehensive Plan goals and FY14 Implementation Plan service category objectives align with several Healthy People 2020 objectives identified across various HP 2020 topic areas. Service category objectives identified in the Implementation Plan for each of the four core medical and two support service categories comprising the largest amounts of Part A funding support Healthy People 2020 goals and objectives listed under *HIV*, *Oral Health* and *Sexually Transmitted Diseases* HP topic areas. Comprehensive Plan goals and FY14 Implementation Plan service category objectives most directly align with Healthy People 2020 objectives in the *HIV* topic area. Healthy People 2020

objectives included under the *Oral Health* and *Sexually Transmitted Diseases* topic areas are also supported by the Atlanta EMA Implementation Plan service goals.

Healthy People 2020 Objective	Atlanta EMA FY14 Implementation Plan Objective							
	PC 1	PC 2	PC 3	HIP 1	OH 1	CM 1	Food 1	PS 1
HIV HP2020 - 1: Reduce the number of new HIV diagnoses among adolescents and adults.	X	X						
HIV HP2020 - 2: Reduce new HIV infections among adolescents and adults.	X	X						
HIV HP2020 - 3: Reduce the rate of HIV transmission among adolescents and adults.	X	X						
HIV HP2020 - 4: Reduce the number of new AIDS cases among adolescents and adults	X							
HIV HP2020 - 5: Reduce the number of new AIDS cases among adolescent and adult heterosexuals.	X							
HIV HP2020 - 6: Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.	X							
HIV HP2020 - 7: Reduce the number of new AIDS cases among adolescents and adults who inject drugs.	X							X
HIV HP2020 - 8: Reduce the number of perinatal acquired HIV and AIDS cases.		X			X			
HIV HP2020 - 9: Increase the proportion of new HIV infections diagnosed before progression to AIDS.	X	X		X	X			
HIV HP2020 -10: Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.	X	X	X	X	X	X		
HIV HP2020 - 11: Increase the proportion of persons surviving more than 3 years after a diagnosis with AIDS.	X	X	X	X	X	X	X	X
HIV HP2020 -12: Reduce deaths from HIV infection.	X	X	X	X	X	X	X	X
AHS HP2020- 1: Persons with health insurance				X				
AHS HP2020-6: Inability to obtain or delay in obtaining necessary medical care, dental care or prescription medicines				X				

Healthy People 2020 Objective	Atlanta EMA FY14 Implementation Plan Objective							
	PC 1	PC 2	PC 3	HIP 1	OH 1	CM 1	Food 1	PS 1
OH-14: (Developmental) Increase the proportion of adults who receive preventive interventions in dental offices.					X			
STD-1: Reduce the proportion of adolescents and young adults with Chlamydia trachomatis infections.	X	X	X					X
STD-6: Reduce gonorrhea rates.	X	X	X					X
STD-7: Reduce sustained domestic transmission of primary and secondary syphillis.	X	X	X					X

(10) **The EMA ensures that resource allocations to provide services for WICY are in proportion to the percentage of EMA AIDS cases represented by each priority population:** As reported in FY12, services provided to WICY met or exceeded the requirements for all categories: Women (21.00% of all persons living with AIDS vs. 24.87% served); Infants (0.01% vs. 0.1% served); Children (0.29% vs. 0.31% served); and Youth (3.64% vs. 3.67% served) with total expenditures of $2,374,444.

(11) **The EMA Planning Council is using MAI funding to reduce disparities in access to care.** As in FY13, the Priorities Committee and Planning Council directed that FY14 MAI funds be allocated to the Primary Care category to reduce disparities to provide comprehensive treatment and care to minority populations. Non-MAI Part A funds will allow for the provision of essential core services that are comprehensive, standards-based, geographically accessible, and remove barriers to care. These services will target disproportionately impacted populations, as well. The use of MAI funding for this purpose is consistent with the EMA's prioritization of Primary Care as the number one priority service category as indicated on the FY14 Implementation Plan.

(12) Results of Unmet Need Analysis were used by the Planning Council in their allocation decisions: The Priorities Committee reviewed the unmet need estimate during the data collection and review phase of the 2014 priority setting and resource allocation process. This year, the unmet need estimate was used to determine the possible impact of new clients entering the Part A continuum of care due to increased and coordinated linkage efforts being implemented by the GDPH in the EMA allocations to four Part A funded sites. The Committee created a new core service category, Health Insurance Program (HIP), to cover the co-pay and premium costs related to patients moving into the Health Insurance Marketplace as the Affordable Care Act takes full effect.

(13) The Planning Council considered/addressed the need of HIV medications by the target population during their allocation process: The Priorities Committee was provided data from *The Consumer Survey* that Medications (Primary Care and AIDS Pharmaceutical Assistance priority categories) ranked 1st and 6th, respectively, as gaps in services needed but not received. In late 2012, the Georgia ADAP received supplemental and emergency relief funds, eliminating the waiting list in FY13. For FY14, Part A funding was allocated to Primary Care for medications and APA to serve as a stop-gap measure while new ADAP and /or PAP applications are processed.

(14) The Planning Council considered/addressed the population groups identified in EIIHA during the allocation process. The population groups are AA-MSM 15-30, AA-MSM 30-45 and AA Heterosexuals. FY14 funds, including MAI funds, were allocated to the Primary Care category to promote access to care for the identified populations. Additional core services were funded to allow access to medications, mental health and substance abuse services, oral health and case management. Support services were funded to facilitate access and retention in care including medical transportation, childcare, emergency financial services, and food and nutrition services.

- ***EVALUATION AND TECHNICAL SUPPORT CAPACITY***

1) Clinical Quality Management

1) A. Description of Clinical Quality Management (CQM) Program

(1) The EMA has an approved quality management plan that establishes processes for ensuring that services are provided in accordance with the Department of Health and Human Service (HHS) HIV/AIDS guidelines and locally defined standards of care. Quality-related expectations have been incorporated into the EMA's requests for proposals and contracts. The CQM Program is designed to address quality assurance and process improvement through the EMA's adopted standards and indicators, patient education and agency staff education, continuity of care, and client satisfaction.

(a) **The CQM plan goals and infrastructure:**

The overall purpose and goals of the quality management program are to develop and implement a coordinated approach to addressing quality management and process improvement for the Atlanta EMA's continuum of care and services. The mission is to design and deliver measurable, systematic processes and procedures through a partnership with providers, consumers and the Grantee. These processes and procedures are used 1) to monitor and improve the delivery of quality services to clients, 2) to assist the Planning Council in its priority setting process, and 3) to assist the Grantee in the administration and monitoring of programmatic and fiscal requirements.

Staff and Committee leadership of the EMA's clinical quality management program are shared by the Council and Grantee. The Quality Management Committee (QM Committee) of the Council and Special Project Assistant on the Grantee's staff are responsible for the day-to-day oversight and management of quality activities. Council members are assigned to the QM Committee at the beginning of each Council year. Members include providers and consumers of Part A services as well as other members interested in Quality Management. Each funded agency is contractually required to have representation on the Committee. The Chair of the QM Committee is appointed annually by the Planning Council Chair and is responsible for convening the meetings and coordinating the work of the Committee in conjunction with the Grantee. The Special Project Assistant from the Grantee is assigned to coordinate the work of the Committee with the Grantee's HRSA requirements and to monitor progress toward the data evaluation and reporting activities. The **QM Committee's** responsibilities include:

- Monitoring compliance with the EMA's Quality Management Plan
- Revising established Quality of Service Indicators (based upon the EMA's adopted Standards of Care) to monitor system-wide measures; changes in indicators are presented for adoption by the Executive Committee and the Planning Council
- Establishing a timeline for collection and reporting of related data in collaboration with the Grantee
- Evaluating data and preparing action step recommendations
- Reviewing EMA chart review results for possible incorporation into Committee work
- Prioritizing opportunities for improvement and approaches to achieve improvement, including delegation of those issues to time limited work groups or task forces
- Monitoring the work of task forces and work groups to remove barriers and accelerate quality improvement
- Reviewing and summarizing existing agency-level quality management mechanisms to inform the Committee and to communicate quality improvement information across the EMA
- Developing spread strategies for sharing of best practices
- Coordinating activities delineated in the Comprehensive Plan

The **Grantee's** responsibilities focus on the development and monitoring of contractual requirements including data collection and presentation of data results to the QM Committee, Priorities Committee, Assessment Committee and the full Council. Goals and objectives, including tasks and timelines, for quality management are included in the EMA's Comprehensive Plan. Annual review of the quality management plan is conducted jointly by the Grantee and the QM Committee.

The Quality Management Budget (approved by the Planning Council) is set at **$174,650** with funding for 10% of the Special Project Assistant's time and for quality management

projects including: updated unmet need report, chart review tool and methodology which incorporates EMA standards and HRSA performance measures, development of cost per unit of service, and completion of special studies required by the QM Committee. Also included are funds to continue the patient navigation pilot program, including an evaluation, initiated in FY13. Funds to support additional time of the Special Project Assistant's position and analysis of the CAREWare data are included in the Grantee's administrative budget. The Special Project Assistant is responsible for monitoring the quality management budget and contracts and reporting progress toward completion of funded activities to the QM Committee and Grantee.

Staff time assigned to quality management is .1 FTE with additional .5 FTE staff time at SEATEC.

The Grantee contracts with the SEATEC for the provision of quality management activities including data collection from chart review at primary care sites, reporting of findings to QM Committee and Planning Council, and training of Committee and Planning Council members.

The CQM resources and training provided to the Grantee, quality management committee and sub-grantees include:

- Analysis of five year utilization data including demographics and service category accessed to guide recommendations for changes in the delivery of services.
- Participation of QM Committee Chair and five additional Committee members in National Quality Center (NQC) Train-the-Trainer and Leadership trainings
- Local training by NQC staff on Quality Measures attended by Parts A, B, C, D and SEATEC
- Participation of consumers at NQC training in Atlanta
- Quarterly Newsletter is produced highlighting an agency's QM program along with EMA progress toward attaining HAB Performance Measures
- Agency presentations at QM meetings to talk about what is working well and to spread best practices
- Participation on NQC webcasts and review at monthly meetings
- Technical assistance from the Grantee or other members in the development of agency QM plans and activities to increase compliance with EMA indicators, (e.g., identification of missing variables in CAREWare that impact results)
- Technical assistance running HAB measures in CAREWare to review agency progress toward compliance with HAB measures

(b) **CQM Program Processes and Activities:**

Specific performance measures being monitored by service category for primary medical care and medical case management are included in the table below. These indicators are measured through data collection from chart reviews and/or CAREWare.

CATEGORY	QUALITY OF SERVICE INDICATORS
Primary Care	90% of clients (enrolled in care $\geq$ 6 months) will have 2 or more medical visits, at least 3 months apart, in an HIV care setting in a 12-month period
	90% of clients (who have been in care for $\geq$ 6 months) will have 2 or more CD4 counts, at least 3 months apart, performed in a 12-month period
	90% of clients with AIDS (enrolled in care $\geq$ 3 months) will be prescribed HAART medication
	95% of clients with a CD4 count below 200 cells/mm (enrolled in care $\geq$ 3 months), with at least one medical visit in the measurement year, will be prescribed PCP prophylaxis
	90% of pregnant women with HIV infection will be prescribed HAART medication (excluding those in first trimester; those enrolled in care during last 3 months of measurement year; and

	those not presenting for prenatal care)
	100% of client medical records will include a problem list
	100% of client problem lists will include documentation of known allergies
	90% of clients on antiretroviral (ARV) therapy will be assessed or counseled for adherence 2 or more times in the measurement year (except those enrolling or initiating ARV therapy during the last 6 months of the measurement year
	90% of female clients 18 and older will have an annual Pap test (except those who have had a hysterectomy for non-dysplasia/non-malignant indications)
	100% of clients who are newly enrolled, sexually active or who have had an STI within the last 12 months of the measurement year will be screened for gonorrhea at least once during the measurement year
	100% of clients who are newly enrolled, sexually active or who have had and STI within the last 12 months of the measurement year will be screened for chlamydia at least once during the measurement year
	90% of clients will be screened for syphilis at least once during the measurement year
	100% of clients will have TB screening documentation in the past 12 months (except those with a history of culture positive TB or previous documented positive test)
	95% of clients will be screened for hepatitis C at least once since the diagnosis of HIV infection
	85% of clients will have documentation of prevention/risk counseling at least once during the 12-month period.
Medical Case Management	80% of MCM clients will have 2 or more primary care visits, at least 3 months apart, in the measurement year
	80% of MCM clients will have an Individual Service Plan developed and/or updated 2 or more times, at least 3 months apart, during the measurement year (except those initiating MCM services in the last 6 months of the measurement year or those who were discharged from MCM services prior to six months of service in the measurement year)

Data collected to date include an analysis of unduplicated CY12 CAREWare data, data from the 2010 chart reviews (Chart reviews are being conducted in FY13), and FY12 client satisfaction surveys. Results are included the table below.

CATEGORY	QUALITY OF SERVICE INDICATORS
Primary Care	**95%** of clients had 2 or more medical visits in a 12-month period
	89% of clients had 2 or more CD4 counts performed in a 12-month period
	86% of clients with AIDS were prescribed HAART medication
	92% of clients with a CD4 count below 200 were prescribed PCP prophylaxis
	58% of pregnant women with HIV infection were prescribed HAART medication
	98% of client medical records included a problem list
	100% of client problem lists included documentation of known allergies
	88% of clients on antiretroviral therapy were assessed or counseled for adherence 2 or more times in the measurement year
	99% of female clients 18 and older had an annual Pap test
	69% of clients were screened for gonorrhea at least once during the measurement year
	68% of clients were screened for chlamydia at least once during the measurement year
	81% of clients were screened for syphilis at least once during the measurement year
	97% of clients had TB screening documentation in the past 12 months
	100% of clients were screened for hepatitis C at least once since HIV diagnosis
	93% of clients had documentation of prevention/risk counseling
Medical Case Management	**75%** of MCM clients had 2 or more primary care visits in the measurement year
	87% of MCM clients had an Individual Service Plan developed and/or updated 2 or more times

Results of chart reviews, performance measures, and client satisfaction surveys are provided to the QM Committee and each of the funded primary care sites. Primary care sites and the centralized case management agency are required to submit a written response on any performance measures that are not within 5% of the EMA approved indicator goal. Responses include an assessment of the reason for not meeting the goal along with a plan for improvement outlining the activities to be implemented, person responsible for monitoring progress and a timeline for completion. Progress toward completion of approved plans is monitored by the Grantee and reports were provided to the QM Committee for review. Based on information provided by agencies, the QM Committee was able to conclude whether or not goals were reasonable for the EMA and provide suggestions for identification of data sources. Focus on HAB Measures by site indicated that agencies were not collecting and reporting all necessary variables to correctly calculate the measure in CAREWare. All agencies were provided a copy of the document *CAREWare fields used to calculate Groups 1-3 HAB Performance Measures* to ensure that data collection and reporting was complete. Several agencies improved their results toward attaining EMA goals.

Data were reviewed and validated by the Grantee and data and analysis were shared with the Planning Council. Data were presented to the QM Committee and the Planning Council. The Committee, which includes staff from the Grantee, reviewed the data for compliance with HAB Performance Measures and EMA indicators and requested additional information required to complete the analysis and validation of data. Quarterly newsletters are provided to the full Planning Council with results of HAB measures. The Chair of the QM Committee reports at each Executive and Planning Council meeting on activities, challenges and successes.

The process to determine priorities for quality improvement projects may be at the agency level or the EMA level. Through its internal QM committee meetings, agencies may identify areas for improvement including wait time, no show rate, etc. The agency will then develop and implement strategies to address the desired outcome. Monitoring of the improvement projects is done at the agency level, by the Grantee and the QM Committee through review of annual QM plans and progress reports and through sharing at the QM Committee meetings. **MAI outcome data** are used to meet the QM Program objectives to improve clinical care by monitoring the success of reduction in viral loads and increase in the CD4s of MAI clients and evaluating barriers to adherence to medications and retention in primary care. FY11 data indicated that:

- 1,163 (72.15%) of 1,612 MAI clients had improved or stable CD4 counts
- 1,164 (72.20%) of 1,612 MAI clients had improved or stable viral load test results.
- 1,105 (72.13%) of 1,532 African American clients had stable or improved CD4 counts
- 1,101 (71.87%) of 1,532 African American clients had improved or stable viral load test results.
- 58 (72.5%) of 80 Hispanic clients had improved or stable CD4 counts
- 63 (78.75%) of 80 Hispanic clients had improved or stable viral load results.

EMA wide quality improvement projects are determined by the QM Committee based either on level of compliance with HAB measures or other information brought to the Committee by the Grantee.

Specific quality improvement projects that are currently being implemented within the EMA include participation by all primary care sites in the **in+care campaign;** quarterly review of performance measure data for comparison with national data to determine next steps;

analyzing the results of the client satisfaction survey; developing additional QM training for consumers; implementing the new screening tool for CM/MH/SA expanded to include Legal Services; and revising the EMA's Quality Plan to more accurately reflect activities of the QM Committee and the comprehensiveness of the QM Program.

Improvement projects implemented and data used to improve service delivery in the EMA including long-range service delivery planning include:

- Chart reviews at primary care sites resulted in improved charting which increased the ability to document compliance with HHS guidelines and assure quality patient care
- Assessment of needs of Hispanic clients resulted in additional linguistic services.
- Phone calls to patients for appointment reminders resulted in increased compliance with appointments for medical and dental services.
- Feedback on agency client satisfaction surveys resulted in modification of home-delivered meal menus to address the needs of the Hispanic population.
- During site visits, five primary care sites indicated that 'wait time' was identified as a concern for patients. Sites implemented successful strategies including (1) scheduling visits with nutritionist or health educator while waiting to be seen by the clinician (2) assigning two additional clerks in the registration area and (3) increasing staff at a satellite clinic.
- The most rural site in the EMA indicated that travel distances to see the clinician was a concern for clients. To address this challenge, the agency holds a clinic once a month in two surrounding counties to reduce client travel time and sees 64 patients who might otherwise not be in care.
- Analysis of patient education needs on available services resulted in the implementation of in-service training sessions and development and display of posters to notify clients of all services including dental and support groups.
- Data sets and resource documents including unmet need data by zip code, utilization data, and the NHAS are being utilized in the development of the EMA's Comprehensive Plan to address activities for linkage to care and monitoring of service quality.
- In response to client feedback, a dedicated phone line for prescription refills was implemented at one primary care site, thus increasing client satisfaction.

Process to implement, monitor, and evaluate the CQM Program at both the EMA and provider level include:

The EMA has had a Quality Management Plan in place since 2007. The Plan includes a quality statement, infrastructure, etc. Standards of care were developed through task force participation with facilitation and research of best practices provided by SEATEC. Indicators were developed by the QM Committee. All indicators are based upon the EMA's adopted standards of care and HAB Performance Measures.

Implementation of the plan included contractual language requiring Part A funded agencies to have a quality management plan in place and to incorporate EMA indicators. Agency plans are submitted to the Grantee annually with second quarter progress reports. An annual QM Committee's work plan is developed, including goals and objectives, activities to be completed and timeline for completion. The work plan encompasses any issues or challenges identified through data review or analysis and includes any responsibilities outlined in the EMA's Comprehensive Plan. The work plan is provided to all members of the QM Committee, the Comprehensive Planning Committee, Chair of the Planning Council and the Grantee.

Monitoring of the plan takes place at the monthly meetings of the QM Committee. At these meetings, progress toward completion of identified activities in the work plan is discussed by members. As indicated, reports are made to the Committee by internal and external stakeholders including results of CAREWare data; chart audits, agency and EMA results on clients satisfaction surveys. Progress is indicated in the notes column of the work plan and provided to the Comprehensive Planning Committee. Progress reports and/or timeline revisions are provided to the Executive Committee and the Planning Council by the Chair of the QM Committee.

Evaluation of the plan is conducted annually by the QM Committee and the Grantee. The QM Committee reviews data collected (from CAREWare, chart reviews and site visit reports), assesses progress, assists the Grantee in evaluating system issues, and makes recommendations to the Grantee and Planning Council to address identified deficiencies which may include agency training, modification of variables and/or indicators or special quality management projects. The QM Committee provides information on quality management activities and progress to the Priorities Committee for consideration during its annual priority setting process.

Specific activities that align with Parts B, C, D and SEATEC include:

- EMA CAREWare user manual and codebook to assure consistency of service data entry within for Parts A, C and D and statewide with Part B
- Participation of EMA QM Committee members and agency representatives in NQC Quality Management webcasts
- Enrollment of all primary care sites in the NQC's in+care campaign to bring patients back into care and keep others from falling out of care
- Attendance by all Parts at EMA QM meetings and Part B QM meetings
- NQC and local QM trainings are jointly attended

Participation of clients in the implementation and evaluation has increased since several consumers attended the NQC Training; the QM Co-Chair is the 1st Vice Chair of the Planning Council and attends the monthly meetings of the Consumer Caucus. The Co-Chair provides updates at the Consumer Caucus meetings and reports any challenges to the QM Committee.

1) B. Data for Program Reporting

(1) **The Management Information System (MIS) used for data operations is as follows:**

- The EMA utilizes CAREWare for data reporting for all Part A funded agencies. All connections use a Cisco VPN client. CAREWare is free, scalable software for managing and monitoring HIV clinical and supportive services and produces a completed Ryan White HIV/AIDS Services Report (RSR) as required by HRSA.
- A centralized data collection system is located at Fulton County Government.
- Security of the database is ensured by Fulton County Government IT.
- The Ryan White Data Manager is responsible for backup, recovery and system availability, monitoring of data to ensure completeness and accuracy of reporting.
- Backups are completed nightly and sent to a disaster recovery site weekly.
- The Data Manager utilizes a test server to verify compatibility of CAREWare upgrades and imported data prior to installation on production server.

(2) **The Grantee's current client level data capabilities for the completion and submission of the RSR include:**

- All (100%) providers are able to report client level data. One (1) out of 17 providers is missing >10% for data elements. This provider has a caseload exceeding 4,500 active clients and was contacted and advised of the data elements that are missing and how to make the necessary corrections. A plan is in place to ensure that all elements are completed within established deadlines for RSR submission at the end of the calendar year.
- Requirements for reporting client level data are included in agency contracts.
- The EMA utilizes a centralized server for data entry of all required variables.
- The Grantee monitors data to ensure compliance with requirements for both real time data entry and client level data requirements.
- The Grantee's Database Specialist provides oversight for the process to ensure compliance with HRSA's reporting requirements.

For CY11 and CY12, the Grantee's process to collect and report client level data to HRSA from all core and support services providers includes:

- Maintaining the latest version and build of CAREWare
- Updating contracts in CAREWare to assure accuracy for reporting
- Assessing the training needs of agency staff to provide relevant technical trainings
- Providing technical training to agency staff to ensure data capture and quality
- Importing data from other databases utilized by agencies in data collection to reduce staff time required for data entry into CAREWare and improve data accuracy through the Provider Data Import function in CAREWare
- Monitoring of client level data to ensure completeness and quality
- Providing reports to agencies regarding discrepancies and timeline for completion
- Submitting client level data to meet HRSA's specifications by required deadlines using the following process

Once all data for CY's 2011 and 2012 were captured in CAREWare, the client level data was exported to an XML file. This file was then uploaded to HRSA's EHB (Electronic Handbook) System, which then read the file and translated the client level data for all core medical and support services for each provider. The Grantee communicated with the providers to ensure that data were entered accurately. The Grantee and providers ran missing data reports to determine if any data elements were missing or unknown. The Grantee monitored the data to ensure that only funded services were recorded.

In CY13, the Grantee is improving data quality by attending HRSA's Ryan White Data Report training held in September 2013 updating the CAREWare user manual to align with any changes, conducting one-on-one and group training as needed, and providing additional technical assistance when discrepancies are detected in the data. Special attention is given to ensuring that data entry specialists record data elements uniformly throughout the EMA. Quality checks are run periodically to identify missing and/or unknown data elements. New service providers are monitored closely during the first 30, 60, and 90 days by the Data Manager.

(3) CQM and client level data were used to increase funding for Medical Case Management and maintain funding for the remaining core services during the priority setting process; FPL data assisted in calculating the need for the establishment and funding of the Health Insurance Program; and determining the need for the pilot program for patient navigation to support the linkage and retention of clients in primary care.

- ***ORGANIZATIONAL INFORMATION***

1) Grantee Administration

1) A. Program Organization. See Attachment 10.

(1) The Board of Commissioners (Board) is the policy setting body of Fulton County Government. The Chairman of the Board (Chairman) serves as the Chief Elected Official for purposes of Part A and is ultimately responsible for the Part A program. The County Manager, who is responsible for the operations of the government and for implementation of Board policies, reports directly to the Board; the Ryan White Program is organizationally located in the Office of the County Manager. The Chairman has delegated authority for day-to-day operations of the program to the Director, Ryan White Program who serves as the Grantee. All staff of the Ryan White Program are involved in the planning functions of the program. All positions are currently filled.

(2) **Providers funded through multiple Ryan White Parts** are able to distinguish which clients are served by each individual funding stream to avoid duplication of service. Part A contractually requires that all client level data be entered into the centralized server assuring uniform reporting. The EMA has a standardized codebook that supports consistency in data collection and entry. A funding source document is completed by each provider at the beginning of the contract year indicating the fund source(s) for each of the services under the priority category. Possible funding sources are indicated including Parts A, B, C, D or HOPWA. After review of the fund source document with the approved agency budget, the Data Manager sets up 'contracts' in CAREWare on the centralized server to allow data entry for tracking and reporting of services. The EMA reports client-level information in the annual consolidated RSR for all clients receiving Ryan White services.

1) B. Grantee Accountability

(1) Narrative

(a) **During FY12 the Atlanta EMA took steps to implement the National Monitoring Standards (NMS)** which included a comprehensive review and comparison of the NMS with the Ryan White Part A Manual, site visit tool and contract language. Documents were modified as needed to ensure the EMA's ability to monitor the required standards and to ensure compliance with the NMS. The NMS were distributed to all Part A providers and a providers' meeting was held to outline contractual and programmatic requirements, monitoring activities including site visits, review the NMS, provide guidance and address concerns of the subcontractors. **The FY13 contract process began with all updated documents that incorporated NMS standards.**

(b) **The Grantee separately tracks formula, supplemental, MAI, and carryover funds** in the County's financial system using individual account codes. The Fiscal Manager monitors and tracks funds in the financial system and provides staff with bi-monthly reports which track all expenditures by fund source. In addition, the Fiscal Manager maintains a detailed spreadsheet of the accounts by line item to track funds by funding source. The Fiscal Manager also audits the budgets on a monthly basis to ensure that the County's Finance Department has accurately applied all charges to the proper fund source. As needed, the Fiscal Manager processes journal vouchers to correct any discrepancies found.

Subcontractors are provided electronic spreadsheets of approved budgets based on priority categories and line items within their contracts. Agencies are required to update and

submit spreadsheets monthly along with their monthly invoice. Project Officers audit invoices and distribute reimbursement requests among the appropriate fund source and provides agencies with an updated copy of spreadsheets with the approved reimbursement request. In addition, the Fiscal Manager audits the approved invoices before processing for payment to ensure that charges are applied to the appropriate funding source.

(c) **To ensure timely monitoring and redistribution of unexpended funds,** Project Officers monitor agencies' budgets monthly to determine if expenditures are in line with approved budgets and are expended according to schedule. Each month Project Officers contact agencies to discuss the percentage of the agencies' budgets that are unexpended to determine if funds will be expended by contract expiration. Agencies are required to submit a formal expenditure analysis at the six month contract period. The Grantee allows agencies to submit budget revisions for funds identified and anticipated as potentially being unexpended as a result of changes in personnel and/or other justified reasons. When an agency's budget revision is not appropriate or not approved, the agency's budget is modified to reflect the reduced budget amount and funds are reallocated. Reallocated funds may be directed to offset shortages in the budgets of other agencies funded for services under the same priority category. If needs exist in other agency budgets for services under a different priority category, revisions are reviewed by the Grantee and presented to the Planning Council for approval. Anticipated unexpended funds in the administrative budget, the clinical quality management budget, and the HIV services budget are reprioritized according to directives of the Priorities Committee and the Planning Council.

(d) **The process and frequency of fiscal and program monitoring** begins during the contract negotiation process when each agency is provided a copy of the *Fulton County Government Ryan White Program Part A Manual*, which delineates reporting requirements, and an electronic spreadsheet of the agency's approved budget by priority categories and line items. Initiation of the contract requires: identification of programmatic, fiscal and data designees responsible for compliance with reporting requirements; goals and objectives linked to approved budget; and, copies of subcontractual agreements. **All subcontractors are fiscally monitored on a monthly basis.** Agencies are required to submit monthly expenditure reports (with appropriate supporting documentation) certified by the programmatic and fiscal designees along with an electronic spreadsheet documenting expenditures by line item and priority category. Separate reports must be submitted for MAI and non-MAI expenditures. Any errors, including the over- or under-expenditure of funds within individual line items are corrected prior to reimbursement. By working with subcontractors on a monthly basis, the Grantee is able to identify potential areas for which the redirection of funds is appropriate. **Subcontractors are required to submit quarterly programmatic reports**, using a format established by the Grantee. Quarterly reports are used by subcontractors to document progress towards agency goals and objectives, as well as identify challenges, accomplishments, technical assistance needs, complaints/grievances filed by clients, and the results of ongoing client satisfaction surveys. Service utilization data (e.g. number of clients served and units of service provided) receive particular attention during the review of subcontractor programmatic reports. These numbers are compared against the monthly data report submitted by each agency to verify accuracy. The Grantee provides technical assistance to agencies that report they are either over-achieving (i.e. served more clients than projected) or under-achieving (i.e. served fewer clients) stated goals and objectives.

(e) Fiscal and programmatic monitoring site visits are conducted at least annually during the program year. During the formal site visits, Project Officers review subcontractors' compliance with fiscal reporting requirements, progress with audit requirements, and strategies for improving performance, as applicable; goals/objectives, budgets, data issues, and quality management plans are also reviewed. Agencies are required to have Programmatic, Fiscal and Data Designees present. Part A Project Officers audit a random sample of client files to verify compliance with eligibility requirements, third party payment sources and compliance with NMS.

(f) **The process and timeline for corrective actions when a fiscal or programmatic related concern is identified** begins with a discussion of issues of concern, determination of cause(s) of problem, identification of technical assistance needs, development of a resolution plan which includes clear goals and objectives with concrete timeframes, and, consequences of not correcting the deficiency as agreed. The subcontractor has 30 days to respond to the corrective action. If it is determined that, after the provision of technical assistance, justifiable extensions, or corrective action plans, a subcontractor cannot meet its contractual requirements, some or all of the subcontractor's funding may be reallocated to other priority categories and/or subcontractors where additional funds may be needed for direct client services. The Grantee has final determination in suspending and/or terminating subcontracts.

(g) **Seventeen (17) contractors are currently funded in FY13.** Programmatic and fiscal monitoring site visits were completed in July, August, and September for all seventeen contractors (100%). Subcontractors will receive a total of two site visits for FY14.

(h) **Improper charges by funded agencies** identified by the Project Officers during reconciliation of invoice and supporting documentation were denied and the invoice adjusted accordingly (e.g., charges for line items not currently funded). Agencies were provided technical assistance to prevent future occurrences.

(i) **All contractors received technical assistance (TA) for FY13** beginning with providing technical assistance to applicants on the RFP process. All applicants received a Technical Assistance Evaluation form in which they could request additional technical assistance for the RFP if needed. **The 17 funded Ryan White Part A subcontractors received various types of technical assistance throughout the grant year** on such items as programmatic policies, CAREWare, spreadsheet entry, and budget revisions, with additional training provided to two (2) new contractors, Recovery Consultants and AIDS Healthcare Foundation. The Data Manager attended the Ryan White HIV/AIDS Service Data Training on September 9th thru September 11th. CAREWare training on development of custom reports, revised CAREWare User Manual, and updated data requirements for Ryan White Service Data Report (RSR) will be provided to all subcontractors in October 2013. Subcontractors may also request additional technical assistance for CAREWare from the Data Manager. Throughout the year, the Grantee provided multiple training and technical assistance sessions to new data entry staff on data entry into the centralized server of services based on the adopted Subservice Codebook for Part A funded services. Furthermore, each subcontractor was provided a copy of the *Ryan White Part A Program Manual* which includes detailed information on the Program's policies and procedures. Subcontractors may request technical assistance from their Project Officer in their quarterly reports or at any time such assistance may be needed. The Project Officers also provide technical assistance at regular site visits and during regular telephone conferences.

(j) **Seventeen contractors (100%) are compliant with the audit requirement in OMB Circular A-133.** Contractors are required to submit the agency's audit to the Grantee no later

than 180 calendar days after the close of the agency's fiscal year or provider a letter from the auditor stating planned submission data. Should an agency's federal funding not rise to the level of requiring an audit in compliance with OMB Circular A-133, an independent financial statement is required to be submitted no later than 180 calendar days after the close of the agency's fiscal year.

(k) **There were no findings in any of the subcontractors' A-133 audit reports.**

(l) **The process for reimbursing contractors/subcontractors, from the time a voucher/invoice is received to payment** begins when Contractors submit original invoices signed by the Programmatic and Fiscal Designees, with supporting documentation monthly, along with spreadsheets that are transmitted electronically showing the expenditures for each budgeted line item. Upon receipt, invoices are date/time stamped by the Grantee and reviewed by the Project Officers for accuracy, reconciled against approved budgets, and processed within three (3) business days of receipt of all required supporting documentation. Invoices are approved for payment by the Director or Assistant Director and forwarded to Fiscal Manager for processing through the County's accounting system.

The process of payment made to contractors/ subcontractors from receipt of vouchers/invoice to reimbursement begins with Project Officers reviewing invoices within three (3) business days for accuracy; a comparison of approved budgets and supporting documentation is completed and a fund source is assigned to be charged for payment. Invoices are then reviewed and approved by the Director or Assistant Director and forwarded to the Fiscal Manager for entry into the accounting system of Fulton County's Finance Department for processing/disbursement of payment. Contractors receive reimbursement within thirty (30) days of approval of invoice. The Fiscal Manager reviews bi-weekly payment status reports from the County's accounting system to ensure contractors receive timely reimbursement of expenses.

(2) **Fiscal Staff Accountability**

(a) Narrative

i) The process used by the program and fiscal staff to coordinate activities, ensuring adequate reporting, reconciliation, and tracking of program expenditures requires Project Officers to complete audits of expenditures on monthly invoices. Supporting documentation and monthly electronic spreadsheets showing the allocation of expenses to individual line items and fund sources are also reviewed for accuracy. Project Officers review and reconcile monthly invoices to ensure that expenses equate to approximately one-twelfth of budgeted funds and are accurately reported. Reconciled invoices are then entered into the County's Finance system for payment. The Fiscal Manager processes invoices through the County's accounting system, applying expenditures to the appropriate fund sources to track expenditures. Monthly meetings between the Project Officers and the Fiscal Manager to discuss/review contractors' budgets along with reviewing formula, supplemental, MAI, Carryover balances. Project Officers review invoices for accuracy in comparison to the approved budgets and assign the fund source to be charged for payment. The Fiscal Manager provides Project Officers with monthly reports, generated from the County's accounting system, showing payments processed and the fund source charged. The Fiscal Manager reviews all reports along with invoices and electronic spreadsheets to ensure accuracy. The Fiscal Manager provides quarterly reports to the Director and Assistant Director of unobligated balances.

ii) The fiscal staff is within the program staff personnel; therefore no organizational chart is required.

1) C. Third Party Reimbursement

(1) Narrative

(a) **The Grantee's process to ensure that contractors are monitoring third party reimbursement** begins with the RFP which requires potential vendors to detail their strategies to coordinate service delivery between Part A and other third party payers (including Medicaid, State Children's Health Insurance Program (SCHIP), Medicare including Medicare Part D, VA, and private insurance, including options available under the Health Insurance Marketplace) along with income generated from third party payers in the most recent fiscal year. Once selected, vendors **contractually agree** that: "*(funds will not be used to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, by another third party benefits program or by an entity that provides services on a prepaid basis."* Additionally, subgrantees have been advised of HRSA policy updates and will be expected to vigorously pursue eligibility for other funding sources and to make reasonable efforts to secure non-Ryan White funds whenever possible for services to individual clients. Subcontractors that provide Medicaid-reimbursable services must be Medicaid certified.

(b) **Subcontractors document and ensure clients are screened and enrolled in eligible programs (i.e., Medicare, Medicaid, private insurance, or other programs including new options with the ACA Health Insurance Marketplace) to coordinate benefits and to ensure that Ryan White funds are the payer of last resort.** In order to be compliant with this requirement, agencies must determine client eligibility for private insurance, Medicaid, Medicare, and the new Marketplace insurances during intake and at least every 6 months thereafter. A copy of the financial screening tool is included in client files. Agency systems include processes to determine and document client income (if the client has no income, documentation must be provided as well as an explanation of how living expenses are provided), assess opportunities for third party enrollment and billing, individual payments and that Part A is payer of last resort. Required documentation includes paycheck stubs for employed patients which may indicate withdrawals for insurance coverage (employment is verified by accessing the Georgia Department of Labor database); income (based on W-2 forms, etc.) to determine financial eligibility for Medicaid; VA coverage; eligibility for PeachCare (SCHIP); Medicare and, Marketplace coverage. Primary care subcontractors electronically access the Georgia Health Partnership Portal to determine whether clients are enrolled in PeachCare, Medicaid, and Medicare.

The Grantee's process for verifying agencies' compliance with payer of last resort requirements includes reviewing a random sample of charts from each agency. As more clients within the EMA begin enrolling in private insurance through the Marketplace, the Grantee will require that agencies verify client insurance eligibility through the use of verification tools such as Passport. Each agency has the flexibility to utilize the tool that best integrates with their existing client data and/or billing systems. The Project Officers will verify during site visits that verification tools are utilized and that clients are screened appropriately at the time of each service. Ryan White Part A funds can be utilized, if requested, by the agencies to support the administrative costs incurred to comply with this requirement.

(c) **The Grantee monitors the tracking and expenditures of any program income** during site visits. Project Officers monitor compliance through a review of client files and financial reports indicating income generated through third party billing. Additionally, this information is reported in the agency's quarterly programmatic report. If a subcontractor were found to be non-compliant, the Grantee's corrective action process would be initiated.

1) D. Administrative Assessment

(1) The Planning Council's Evaluation Committee reviewed the efficiency of the administrative mechanisms implemented by the Grantee in rapidly disbursing funds to the areas of greatest need. The Committee surveyed funded agencies and compiled the results, which were reported to the Planning Council on September 19, 2013. Fifteen (15) agencies were surveyed and all (100%) responded. Based on the mean scores (on a scale of 1-4), the Grantee either met or exceeded each of the required criteria.

(a) In addressing timely payments, the Grantee scored 3.6 out of 4.0. The score for processing contracts in a timely manner was 3.5 out of 4.0.

(b) **No deficiencies** were identified.

1) E. Maintenance of Effort (MOE): See Attachment 11.